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QUALITY OF U.S. HEALTH STATISTICS AND TO REVIEW YEAR 2000 OBJECTIVES

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT INFORMATION
AND REGULATION

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

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QUALITY OF U.S. HEALTH STATISTICS AND TO REVIEW THE YEAR 2000 OBJECTIVES

TUESDAY, MARCH 20, 1990

United States Senate,
Subcommittee on Government Information
and Regulation,
Committee on Governmental Affairs,
Washington, DC.

The Committee met, pursuant to notice, at 9:35 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Jeff Bingaman, Chairman of the Subcommittee, presiding.

Present: Senator Bingaman.

Staff present: Edwin S. Jayne, Staff Director; Carole Hardwick; Chief Clerk; Robert Moore, Fellow; Ann Schnittker, Staff Assistant; and Richard Ashooh, Minority Professional Staff Member.

OPENING STATEMENT OF SENATOR BINGAMAN

Senator Bingaman. The hearing will come to order.

This is the first of two hearings that we are having in the Subcommittee on Government Information and Regulation on the quality of U.S. health statistics and progress in reaching national health goals. In particular, I hope we can review our current statistical gathering efforts in the context of the Public Health Service's Year 2000 Objectives for the Nation.

Is our Nation getting healthier or less healthy? We hear many different opinions, but we do not always have the information we need to make a truly informed assessment of our national health status. The Public Health Service has developed a document detailing a long list of national health goals, priority areas, and objectives, highlighting areas where improvements can be made within the next 10 years before the turn of the century. This document, which is still in draft form, is being circulated to Federal agencies and State and local and voluntary health organizations for comment. The project is based on the Health Service's extensive public health work during the past 10 years and has met with great success, yet it faces many challenges as we go forward.

I know a great deal of credit for the work goes to the Department and to the Public Health Service for their excellent efforts. The plan lists five specific goals. First, to reduce infant mortality to no more than seven deaths per 1,000 live births; second, to increase life expectancy to at least 78 years; third, to reduce disability caused by chronic conditions to no more than 6 percent of all people; fourth, to increase the years of healthy life to at least 65 years; and fifth, to decrease the disparity in life expectancy between white and minority populations to no more than 4 years.

These goals reflect an emphasis on the quality rather than the quantity of life. The goals do not reflect a perfect state of public health. They are targets for the next 10 years and part of an even longer process for improving our public health.

The first goal, the reduction in infant mortality rates, indicates some of the problems that we face as a Nation. In 1986 there were 10.4 infant deaths per 1,000 live births in the United States. That statistic is too high, but unfortunately that is not the worst statistic. Black infants die at almost twice the rate of whites, 18.2 versus 9.2 per 1,000 live births between 1984 and 1986. Many other countries, including Japan with 5.5, Iceland with 6.1, Finland with 6.3, Sweden with 6.8, and Switzerland with 6.9, have already surpassed our own goal for the year 2000. In fact, 21 industrial nations had lower infant mortality rates than the U.S. in 1985. These countries were in Europe, Asia, as well as Canada and Australia. Our target—no more than seven deaths for every 1,000 live births—is still a long way from where we as a Nation should be.

The five broad goals of this program are accompanied by 21 priority areas which in turn are divided into several hundred specific objectives. These objectives include expanding the medical school curriculum, providing better public health education, improving worker safety, reducing the incidence of violence and abusive behavior. And targets are set aimed at the lowering of alcohol consumption, implementation programs that address the problems of tobacco and drug addiction, and developing mechanisms for providing better preventive health services.

As we begin working toward the health goals for the year 2000 we need to know how well we are doing in each area. We need to make adjustments in our health promotion strategy when necessary based on this information. Existing data must be compiled and new data may be needed to judge the appropriateness of our existing strategies. The results and analysis of data collection efforts should be publicized and made available to State and local public health officials and the general public. Each one of us should be able to assess the progress that our local organizations are making and apply pressure to intensify efforts if necessary. Publication of national results and the development of reliable timetables can serve as useful benchmarks for States and localities.

Today's hearing will concentrate on general programs, the effects of the year 2000 objectives on the Federal agencies and the data needs that are being addressed currently. I find it ironic that at a time when we should be expanding our collection efforts in this area we are apparently reducing the budget for the National Center for Health Statistics. We will hear testimony about the relevance of the objectives and the effects on Federal agencies of a total Government effort to comply with and advance these recommendations.

During this Subcommittee's second hearing scheduled for April we will hear testimony from State, voluntary, and industrial organizations about the year 2000 objectives from their point of view.

I regret that despite the invitation that we made to the Department of Education, it has declined to testify on this subject. My staff contacted the Assistant Secretary for Educational Research and Improvement several weeks ago in an effort to solicit testimony and was led to believe that testimony would be provided if a letter of invitation was sent. The letter was sent. Subsequently we were told by the Office of Congressional Affairs that no witness would be provided to either of these two hearings. Initially the reason given was that the Department did not believe it had sufficient responsibility for health statistics to have anything to say.

I think this is unfortunate. I hope it is not the view of the entire Department, because it is obvious that the Department of Education does have significant responsibility in this area. Several dozen of the objectives hope to affect the Nation's health through local schools. Issues such as health education training, nutrition education for preschool through 12th grade, education in lifetime fitness practices, health screening in schools, continued education for teachers, recognition of abused children and children at risk of suicide and much more are just some of the major responsibilities that the Department of Education has in this area.

Despite the lack of a witness today, I hope the Department of Education is cooperating with HHS' promotion of these goals and will do all it can to further these objectives. These responsibilities need to be given serious attention.

I look forward to the testimony today, and our first panel consists of three individuals; the Assistant Secretary of Health, Dr. James Mason, accompanied by Dr. Michael McGinnis, who is Deputy Assistant Secretary of Health. And in addition, Dr. Feinleib is Director of the National Center for Health Statistics at the Centers for Disease Control in the Department of Health and Human Services.

We are very pleased to have all three gentlemen here and we look forward to your testimony. Dr. Mason, why don't you begin.

[The prepared statement of Senator Bingaman follows:]

PREPARED STATEMENT OF SENATOR BINGAMAN

This hearing will come to order. Today's hearing is the first of two hearings the Governmental Affairs Subcommittee on Government Information and Regulation has scheduled on the quality of U.S. health promotion statistics. In particular, I hope to review our current statistical gathering efforts in the context of the Public Health Service's Year 2000 Objectives for the nation.

These hearings ar part of this subcommittee's ongoing series of hearings on the quality of government information. Last year we held three days of hearings on information quality, with two of the hearings focusing on education statistics and databases. It is clear to me as chairman of this relatively new subcommittee that we are not focusing enough attention on these issues until we have evidence of a major problem in an agency's ability to collect information. During today's hearing, I hope we will hear of an area of the federal government where information collection efforts are going well, but where still more attention needs to be directed if we are to achieve the best possible results.

Is our nation getting healthier or sicker? We hear many different opinions, but we do not always have the information we need to make a truly informed assessment of our national health status. The Public Health Service has developed a document detailing a long list of national health goals, priority areas, and objectives, highlighting areas where improvements can be made within the next ten years, before the next millenium. This document, still in draft form, is being circulated to federal agencies, and state, local and voluntary health organizations for comment. This project which is based on the Public Health Service's extensive work during the last 10 years, has met with great success; yet it faces many challenges so far. I know a great deal of credit for the work goes to the Department and the Public Health Service for their excellent efforts.

The Public Health Service plan lists five specific goals:

GOALS

(1) To reduce infant mortality to no more than 7 deaths per 1,000 live births.

(2) To increase life expectancy to at least 78 years.

(3) To reduce disability caused by chronic conditions to no more than 6 percent of all people.

(4) To increase years of healthy life to at least 65 years.

(5) To decrease the disparity in life expectancy between white and minority populations to no more than 4 years.

These goals reflect an emphasis on the quality as well as the quantity of life. The goals do not reflect a perfect state of public health. They are merely targets for the next ten years and part of an even longer process for improving public health.

The first goal—a reduction in infant mortality rates—indicates some of the problems we face as a nation. In 1986, there were 10.4 infant deaths per 1000 live births in the United States. That statistic is just too high; but it gets even worse. Black infants die at almost twice the rate as white (18.2 versus 9.2 per 1,000 live births between 1984 and 1986). Many other countries, including Japan (5.5), Iceland (6.1), Finland (6.3), Sweden (6.8) and Switzerland (6.9) had already surpassed our year 2000 goal by 1985. In fact, 21 industrial nations had lower infant mortality rates than the U.S. in 1985. These countries were in Europe (France, Norway, Spain, Ireland, West and East Germany, Italy), Asia (Hong Kong, Singapore) as well as Canada and Australia. Our target—no more than 7 deaths for every 1000 live births is still a long way from where we as a nation should be.

PRIORITY AREAS

The five broad goals of the Public Health Service program are accompanied by 21 priority areas, which in turn are divided into several hundred specific objectives. These objectives include expanding medical school curriculum, providing better public health education, improving worker safety, and reducing the incidences of violence and abusive behavior. Targets are set, aimed at lowering alcohol consumption, implementing programs that address the problems of tobacco and drug addiction, and developing mechanisms for providing better preventive health services.

In many areas simple changes in behavior can have a great and positive impact on the state of our public health. Other areas are ripe for intensified research effort. By encouraging proper nutrition, exercise and responsible behavior, we can add years to our collective lives. Confronting the problems of violence, abusive behavior, alcohol abuse, tobacco and other dangerous drug use, could result in longer lives and also expanded personal freedom. Working to prolong the vitality and independence of older people helps maintain the dignity and productivity of the generation that survived the Depression and World War II and built a society that has brought peace and prosperity to the nation.

As the Public Health Service objectives point out, violence and abusive behavior—largely due to drug and alcohol abuse—are serious health issues. The suffering caused by homicide, suicide, firearm injuries, child abuse, assault and rape must be reduced. Homicide is a terrible problem, killing 8.7 people per 100,000 nationwide in 1986. Even more deaths were caused by suicide (11.9 per 100,000) and firearm accidents (13.7 per 100,000).

As we begin working toward the health goals for the year 2000, we need to know how well we are doing in each area. We need to make adjustments to our health promotion strategy when necessary based on our knowledge. Existing data must be compiled, and new data may be needed to judge the appropriateness of our existing strategies. The results and analyses of data collection efforts should be publicized and made available to state and local public health officials and the general public. Each one of us should be able to assess the progress that our local organizations are making and apply pressure to intensify efforts, if necessary. The publication of national results and the development of reliable time tables, can serve as useful benchmarks for states and localities.

But any effort to achieve these national health goals must begin with the individual. If we want to see improvement in the national data each one of us must adopt healthy lifestyle practices. We must promote better health for each one of us, our families, and our local communities. Greater attention to the deadly problems associated with the use of tobacco and greater intolerance for the tobacco industry's efforts to target minorities, women and children, could substantially improve national longevity, and help reduce the problems and costs of low birth weight babies. More personal restraint on the use of alcohol would certainly lead to improvement in the nation's health. The encouragment of proper nutrition, regular exercise, and the development of stress reduction programs in our nation's schools and businesses would certainly help meet many of the goals set forth in the Year 2000 Objectives, and each would have a lasting effect on our quality of life.

EFFECTS ON FEDERAL AGENCIES

Today's hearing will concentrate on general programs, the effects of the Year 2000 objectives on federal agencies, and the data needs that are being addressed currently. I find it ironic that at a time when we should be expanding our collection efforts in this area, we are apparently reducing the budget for the National Center for Health Statistics. We will hear testimony about the relevance of the objectives and the effect on federal agencies of a total government effort to comply with and advance the recommendations. During this Subcommittee's second hearing, scheduled for April, we will hear testimony from state, voluntary and industrial organizations about the Year 2000 objectives from their point of view.

I look forward to the testimony of our witnesses.

TESTIMONY OF JAMES O. MASON, M.D., DR.P.H., ASSISTANT SECRETARY OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY MICHAEL J. McGINNIS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH

Dr. MASON. Thank you, Mr. Chairman. We are pleased to be here today to discuss the National Health Promotion and Disease Prevention Objectives for the Year 2000. I would like to abbreviate my spoken testimony if I could submit for the record my entire testimony.[1]

Senator BINGAMAN. That would be fine, you can do that.

Dr. MASON. As you know, the year 2000 health objectives initiative builds upon our experience over the past decade in using a management-by-objectives process to set out a strategy for using health promotion and disease prevention to improve the health status of the American people. In 1980 the publication of "Promoting Health/Preventing Disease: Objectives for the Nation" set forth 226 measurable objectives arrayed across 15 priority areas for preventive interventions with targets to be achieved by the year 1990.

It was clear from the beginning that any health promotion and disease prevention effort would only make real sense if it was a national effort rather than just a Federal one. Health promotion and disease prevention must engage individuals at local and state as well as Federal levels of Government. Also, the private sector and the many crucial private voluntary and professional associations and organizations are essential.

In 1987, we began the process that will culminate this coming September in the publication of a new set of objectives to guide our health promotion efforts during the 1990s. The year 2000 health objectives will be published under the title "Healthy People 2000." This process has involved a much more extensive, grassroots approach than was the case of the development a decade ago. There have been five separate phases in the developmental process: a planning phase that began in 1987, a public input phase in 1988, a drafting and review phase in early 1989, a public review and comment phase in late 1989, and now in 1990 final preparation of the objectives for release at a national conference to be held in September of this year.

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[1] See p. 71.

A set of criteria has governed these objectives. Chief among these are measurability and realism. In keeping with the basic philosophy of management-by-objectives, the quantified targets that are being set for attainment by year 2000 are meant to be taken with the same kind of seriousness that business people take their production and sales targets. The targets should be measurable and challenging, but they should not be unattainable or unrealistic.

Measurability does not, however, mean that we have to forego setting targets that address subjects for which we lack existing baseline data. Rather, it means we must be able to measure, even if we have not done so yet.

Based on the draft objectives, most of the health status and risk reduction objectives are currently measured by annual or periodic surveys, most of which are conducted by the Public Health Service through ongoing surveillance and sample survey programs. A subset of objectives, particularly those that address the extent to which services are provided, do not have currently available baseline data and will require special surveys to begin measurement toward their attainment.

You ask if further resources will be needed to promote or to monitor the objectives. In general terms, the answer is yes, but I cannot say whether that means additional money. The very nature of the objectives process implies that more effort is needed in certain areas, but it also implies that goals should be more readily met through focused activities. The objectives can serve as a catalyst for change, as an energizer of various relevant sectors of public and private sectors, and as a framework for decision making about fiscal resource allocation.

Fiscal resources to support the year 2000 objectives are clearly not unlimited, whether we are talking about Federal, state or local public funds or those available to employers to support health promotion and disease prevention at the workplace or those available to individuals. We think that one important aspect of these objectives, however, will be their utility in defining opportunities where fiscal investments will bring the highest returns in individual health and long-term saving. In addition, these objectives help us to recognize that improvements in health call for the appropriate use of resources that are usually not considered part of our health care expenditures.

Your question about an annual checkup on the Nation's health using the year 2000 objectives is a provocative one. In fact, we plan for "Healthy People 2000" to provide a set of about 25 summary or flagship objectives that can be used to tell us about the Nation's "vital signs," to continue your annual health checkup analogy.

You will hear later from Charles Stokes, who is chairman of the Model Standards Coordinating Committee, representing 4 national organizations that developed a set of standards to guide the work of state and local health agencies to set their own targets. That group will publish later in 1990 a new version of its Model Standards for Community Programs, in the form of a workbook that uses the year 2000 objectives as its template to assist states and localities as they take the national objectives to the community level where the changes envisioned in year 2000 targets must actually occur.

We are hopeful that many States will develop their own specific year 2000 plans, choosing from the array of priorities and objectives in the national document. Many states have already informed us of their intention to do just that.

Your final question raises the issue of the Federal Government addressing the kind of improvements for its own employees and programs that the year 2000 objectives calls upon the whole Nation to undertake. As an employer, the Federal Government has begun seriously to support development of health add fitness programs by its various agencies. A current project, collaboratively supervised by the Office of Personnel Management and my office in PHS, and implemented by the Association of Schools of Public Health, is developing a qualitative evaluation of selected sites where such programs have been most fully developed for use as guidance to agencies that are only at the first steps in organizing such efforts.

One of the sites being reviewed, Mr. Chairman, is the Federal establishment at Los Alamos, New Mexico. As an insurer through its Medicare and Medicaid program, there are clearly some difficult policy decisions to be made in the coming years about the appropriateness and effectiveness of reimbursement for preventive services. Major improvements have occurred recently in extension of coverage for prenatal care, one of the most importance of our preventive interventions and a key objective in the year 2000 plan.

Demonstrations are looking at issues of feasibility and effectiveness of packages of prevention services for Medicare recipients. As a health care provider through such programs as the Indian Health Service, the Federal Government is already leading the way. Indian Health Service hospitals were the first in the Nation to be smoke-free hospitals. An Indian Health Service health promotion and disease prevention initiative based in Albuquerque has engaged all of the tribal nations in planning that goes beyond the clinic and reaches into Indian schools and communities with programs aimed at the prevention and control of diabetes, alcohol abuse, safety, and other important areas of prevention.

In short, "Healthy People 2000" does not discriminate. It is meant for all the American people, whether publicly or privately employed, whether enrolled in public or private insurance programs whether receiving health care services from private providers or public clinics.

Mr. Chairman, I have briefly described the background and process of developing health promotion and disease prevention objectives for the year 2000, and we have tried to respond to the questions that you posed in your letter of invitation to the Secretary. We will be happy now to respond to any additional questions you may have. Thank you for this opportunity.

Senator BINGAMAN. Thank you very much.

Dr. McGinnis, do you have comments initially also?

Dr. MCGINNIS. No, I don't, Mr. Chairman.

Senator BINGAMAN. Okay. Dr. Feinleib, go right ahead.

TESTIMONY OF MANNING FEINLEIB, M.D., DR.P.H., DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS, CENTERS FOR DISEASE CONTROL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. FEINLEIB. Thank you very much, Mr. Chairman for this opportunity to join you today to discuss the data issues involved in the year 2000 objectives. I will provide you with a brief overview now in my oral remarks and, if I may, submit my full statement for the record.[1]

Senator BINGAMAN. It will be included in the record.

Dr. FEINLEIB. I would like to briefly review the needs for data for measuring the objectives and the sources of that data. Then I will discuss some of the challenges we face. I will conclude by outlining some of the initiatives we are planning to enable us to meet these needs.

First, the data needs for measuring the objectives. Responsibility for identifying and providing data for monitoring the objectives is shared by many agencies throughout the Federal Government, in State and local governments, and also in the private sector. In developing the objectives the various interagency working groups operated under two data related guidelines. First, all objectives were to be quantified and measurable in order to allow an assessment of progress. Second, although objectives were to be measurable in principle, the current availability of data was not to be a primary consideration in determining the nature of the objectives. We anticipate that most of these data needs can be met through existing data systems, or modifications of them.

Our most immediate task is to identify and provide data for establishing baseline measures in each of the objective areas. Based on a review of the draft objectives published for public comment in September of 1989, we estimate that baseline data already exist for about 70 percent of the draft objectives. The objectives are currently undergoing revision based on the public comments. We are unable to provide a precise estimate of the extent to which we have baseline and tracking data for the final objectives, in part because the objectives are still under revision and in part because survey plans for the next several years have not yet been finalized.

Let me turn now to an overview of the sources of data we will be relying on. Data systems of the Centers for Disease Control, including the National Center for Health Statistics, will assume a large share of the responsibility for establishing baseline measures and for tracking progress in meeting the objectives. CDC will have lead responsibility for the priority area directed at improvements in surveillance and data systems. As the Nation's principal health statistics agency, NCHS will provide data from national surveys for many of the objectives. We will work with other lead agencies to meet data needs of individual objectives, and we will provide overall coordination for tracking and monitoring progress.

My written statement describes the diverse surveys and data systems of NCHS, as well as many surveillance systems of other CDC components. These systems will be the cornerstone of our monitoring effort, augmented by numerous systems throughout the Federal Government, the State and local governments, and through private professional organizations.

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[1] See p. 85.

Now I would like to turn to some of the challenges in meeting the data needs we have identified. One of the most important purposes of the year 2000 objectives is to challenge public health officials to new achievements. In each area these objectives offer accomplishments beyond what would be expected in the absence of the focus provided by the year 2000 objectives process, and beyond what would be obtainable with current efforts. Meeting the data needs of the Nation for the year 2000 objectives presents challenges as great as those found in any of the individual health objectives.

Among the most important challenges are, first, measuring the health of special population groups. Morbidity, mortality, access to health services and health behavior vary markedly by age, race, sex and socioeconomic status. Recognizing these differences, many objectives have special targets for minority groups. In many cases, however, there are little or no data about these groups. A second challenge is developing approaches for measuring objectives not currently measured at baseline. A third challenge is improving access to data for tracking the year 2000 objectives. Despite limitations, data from many of the objectives are currently available from existing data sources. Further efforts are necessary to improve electronic access to data and to make the data available in a form that can be easily used.

A fourth challenge is maintaining the viability of the existing data systems that provide data to track the year 2000 objectives. Potential data sources have been identified for a majority of the objectives. We are committed, to the maximum extent possible within the resources available to us, to maintaining the scheduled data collection for national surveys during the decade to monitor these objectives adequately.

And a fifth challenge is improving data at the State and local levels. Even if data were available for tracking all of the objectives at the national level, our job would be less than half done. Inherent in the approach to the year 2000 objectives is the central role of State and local public health officials in adopting objectives of highest priority in their own jurisdiction. I understand that Garland Land, who will be speaking for Dr. Stokes, will address some of these needs shortly.

Finally, a word about initiatives in the surveillance and data systems priority area. The inclusion of explicit objectives for the improvement of surveillance and data systems in this process ensures that the attention of public health officials will be directed to meeting the challenges over the next decade.

The intent of the objectives in this priority area are, first, to assure that data are obtained for all national objectives, including the specific population subgroups where needed. Second, to develop standard methods that can be used at the national, State and local levels to produce comparable data for monitoring the objectives.

A third objective is to assure that each State collects and analyzes data for at least half of the priority area. Fourth, to develop a system for the timely and rapid transfer of data and other health information related to the year 2000 objectives. And finally, to develop a set of health status indicators that can be used to assess health by agencies at the national, State and local level.

To conclude, we are committed to develop, to the maximum extent possible within the resources available to us, the data systems needed to fully address the year 2000 objectives. We look forward to the significant challenges in addressing all of the implications of this process. The explicit attention given to surveillance and data systems as part of the year 2000 objectives process is an encouraging sign that important needs for data on our Nation's health will be addressed over the next decade.

I would be happy to respond to any further questions you may have. Thank you.

Senator BINGAMAN. Thank you very much, Dr. Feinleib.

Dr. Mason, regarding the establishment of goals as has been done with the year 2000 goals, the obvious implication of that is that once goals are established and methods monitoring progress toward goals are put in place, that then drives the allocation of resources and gives you a way of setting priorities as to what we spend.

Is it your view that these goals that are identified here are in fact having that effect on the Administration's allocation of resources in different areas of health promotion and disease prevention?

Dr. MASON. Indeed they are, and this is an interesting process of developing year 2000 goals. All of the agencies in the Public Health Service are participating in that process, and particularly as we now plan for the fiscal year 1992 budget. Now that we know the priority areas and have identified, cooperatively with people at the state and local and private sectors, what the measurable realistic objectives will be, we can begin focusing our own programmatic plans and budgets in the context of the year 2000 objectives. Yesterday in meetings with the agency heads of the Public Health Service I discussed with them that indeed our budget planning and our program plans ought to reflect the year 2000 objectives.

State and local health departments, as they did with the 1990 objectives, are also focusing attention on these goals and what they need to do to get in line. So I think it does have a focusing type of a pressure. I don't want to really call it a pressure, but it enables us at all levels of Government, in cooperation with the public and private sectors, to begin to focus our attention and begin to target resources toward those things that the Nation needs to accomplish.

Senator BINGAMAN. You indicated that the objectives are still under review. Is there still, as you see it, realistically going to be changes in what is proposed, or are we in the process of finalizing these? My impression is that there has been so much work already put into this that 97 percent of the changes that might be made, have already been made. Am I wrong?

Dr. MASON. I am going to ask Dr. McGinnis to really comment on that specifically. But when the draft document was produced, over 13,000 copies were submitted to individuals and organizations across the Nation in September. The changes that are being made are in response to communications, verbal and in writing and otherwise.

Dr. McGinnis, why don't you comment on how close we are to the final product?

Dr. McGinnis. Well, I think Dr. Mason has stated it very well. This document represents, I think, a good approximation of what will ultimately emerge, but it is not the final word, because when you have 13,000 copies submitted for review, you are going to receive a lot of comments, and we have. And we take those comments seriously. We are looking each of them over very carefully. There will be some changes. There will be some changes that are broader in some of the areas than in others. For example, the area of environmental health, we think, was weaker than it should be, so there will be some extensive changes in that area. In the area of tobacco and health, though, there was a substantial amount of agreement with the way the initial draft was stated so there will be very few changes. And so on and so forth down each of the priority areas.

If you are looking this document over carefully you will have a pretty good sense of where we will end up, but there will be changes.

Senator Bingaman. And when will all the changes be complete and the goals settled on and the objectives——

Dr. McGinnis. The announcement is scheduled for September 6.

Senator Bingaman. And once those are published and distributed to the world at large, how often during the 1990s are we scheduled to have a status report on progress toward reaching those goals?

Dr. McGinnis. The status report will be undertaken in several ways. First, in the upcoming announcement of the Secretary's release of "Health U.S. 1989" there will be a prevention profile. Every 3 years the annual volume "Health U.S." includes a prevention profile which reviews progress toward the objectives. In addition, in 1986 we——

Senator Bingaman. Did you say every 3 years?

Dr. McGinnis. Every 3 years, that's correct.

Senator Bingaman. When is the next one?

Dr. McGinnis. This is 1989, so the next one will be 3 years from now, for reporting in 1992 I guess.

In addition, we will do a comprehensive mid-course review, as we did last time around. So in 1996 or thereabouts we can expect a report on where we were as of 1995. But because we will be developing these flagship objectives, that is, a subset of 25 or so which will, we hope, give a better indication of where we are going with respect to the whole set of objectives, we may be able to report more frequently, even as often as annually, but we haven't yet finally determined that.

Senator Bingaman. Okay. What I am trying to determine is, to what extent is the information that goes into this prepared for public consumption? Maybe, Dr. Feinleib, you are the right one to respond to this. Is this just aimed at the public health officer community, or is this something that the general public can understand and follow as we go through the 1990s? If I am sitting out there watching television, am I able to understand whether the country is significantly accomplishing some of these goals, or do I have to get a statistician to interpret it for me?

Dr. **Feinleib**. Yes, Mr. Chairman, I certainly hope that you will be able to understand them. We have every intention of putting them out in an understandable form. For example, Dr. McGinnis just hesitated because the "Health United States 1989" is scheduled to be released by the Secretary on Thursday morning, and I hope we can wait until then to provide you with a copy which includes the current health profile.[1] But as part of that process the Secretary will be speaking to the general public to highlight the main results of——

Senator **Bingaman**. Now, will this report that he is coming out with this week be the baseline as best we can determine it at this point?

Dr. **Feinleib**. This will cover the progress toward the 1990 objectives, through the year 1989.

Senator **Bingaman**. But you talked about the need to first of all get baseline data in each of these areas.

Dr. **Feinleib**. Right.

Senator **Bingaman**. When do you publish that baseline data?

Dr. **Feinleib**. We have baseline data, we estimate, for about 70 percent of the objectives from currently ongoing systems. So they were either collected through regular systems through this year—for example, the National Health Interview Survey for 1990, which is currently in the field, is both measuring the progress of the year 1990 objectives as well as providing some of the baseline data for the year 2000 objectives. For many of the other systems such as the mortality data, we have that as an ongoing national system which is reported every year in a variety of forms.

Senator **Bingaman**. But do you publish something which pulls together and aggregates the baseline data so that someone could say, here are the objectives and here is where we are, and then two years from now they could look at it and——

Dr. **Feinleib**. There were various reports on this. Dr. McGinnis can speak to this, but we have progress reports, the mid-decade progress report, for example, and other periodic reports that outline the progress.

Dr. **Mason**. I think it is important that any data availability be not just national data. If this is going to work, data has to be available at the State level, the community level, and it is not only making sure that we periodically release national data that is a summation of everything that is occurring on a national level, but, if we are really going to make progress, it means that every State health officer needs data at his or her fingertips. At the community level that same kind of data has to be available, and so we are trying to put into place systems that will provide data at all levels of government so that you can do a report card not just on what the Nation is doing, but each State, and each community. It is putting that kind of network together that I think is our real challenge.

The national data will be disseminated through a number of publications that are put out by the Public Health Service, one of which is the Morbidity and Mortality Weekly Report. This report is picked up by the press. So I think we have a number of ways that we can communicate that not only to health officials but the general public as well.

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[1] See p. 212 for an excerpt. The full report, "Health United States 1989," DHHS Pub. No. (PHS) 909-1232 is available for sale. To order contact: The Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Senator **Bingaman**. We talked a little bit about the possibility of having a national report or checkup or something that would take the information that is coming out in all of these health agency publications and boil it down into something that is a little more comprehensible to the general public and would be regularly released.

Does that kind of thing make sense, or is that happening any ways, or is that not appropriate in light of what you folks are trying to do?

Dr. **McGinnis**. Let me take a quick crack at that and really elaborate on what Dr. Mason was saying. I think one of the frailties of the 1990 process was the fact that it wasn't accessible enough to the general population. We weren't able to reach broadly enough in terms of awareness of the objectives process to the general public, so we have worked very hard on that for the year 2000 process, and that is why we will be identifying these flagship objectives.

And in the course of identifying those objectives, there are in effect three questions that we ask ourselves in trying to determine which ones are flagship objectives. One, are these the most important objectives reflective of the whole progress of the Nation toward better health; two, can these objectives be easily understood by the public and easily interpreted by the media, and three, will there be State and local data sources available around these particular objectives in order for them to pick them up and track them for their own purposes.

If we are doing our job well we ought to be able to provide a subset of a couple of dozen or so objectives that could readily be monitored and should be reported on a regular, even an annual, basis in order to make the awareness of the public more acute.

Senator **Bingaman**. Okay. You say 70 percent of the objectives we have baseline data for. Is it possible to generalize about those areas in which we do not have baseline data, the types of areas, the types of objectives that we really are deficient in?

Dr. **Feinleib**. The areas where we have the greatest lack of information are those that pertain to actual behaviors by the population, what they are actually doing with regard to some of the prevention objectives. Some of them we have good data on, like smoking, but for many of the other topics the methodology has not been in place to get the detailed information about what people are doing, rather than just addressing their knowledge or attitudes about various areas.

Another major area—again, these are in regard to the draft objectives, and the final objectives may be different—involves services provided by professional groups, what the average physician does in the way of preventive services in his office. This has not been an area of great inquiry yet by the various surveys in the field, and we are trying to modify the surveys to see what preventive services are actually being provided.

Senator **Bingaman**. One of the things which has always struck me is that by categorizing our activities and programs in different areas we have things that fall in between the cracks. One example is health and education. We have things that are done in the health area and we have things that are done in the education area, but the things that are a little of both generally fall between the cracks. That has been my perception. Perhaps it is wrong, and if any of you disagree with it, I would be glad to hear your point of view.

But your governors and the President have come up with their goals and some tentative objectives for education. One of the goals is that all children in America will start school ready to learn. Right below that goal, looking at the objectives, it says that children will receive the nutrition and health care needed to arrive at school with healthy minds and bodies, and the number of low birth weight babies will be significantly reduced through enhanced prenatal health systems.

To what extent are we geared up to measure our progress toward achieving these objectives? Is that something that we are geared up to do right now?

Dr. **Mason**. Let me just begin and then my two colleagues here will comment in greater depth. But one of the high priority areas of Secretary Sullivan and myself is doing something about the Nation's problem of high infant mortality. Certainly your remarks in opening this session highlighted the problem that we have here in the United States. So providing access, providing simplicity, one stop shopping, case management, outreach, providing easier availability of the women-infants and children supplemental food products from the Department of Agriculture, all of these are high priorities for the Department of Health and Human Services.

And the database, Dr. Feinleib, do you want to comment on that?

Dr. **Feinleib**. I think we have some information from several of our surveys on this, but it is related to knowledge and attitudes. Some of the practices that we hope to get at later will involve educational efforts.

Senator **Bingaman**. I have a basic question that I am asking here. If we take the education goals that the President announced in the State of the Union address and the governors have been working seriously then we get them down to the objectives to reach the goals which say children will receive the nutrition and health care needed to arrive at school with healthy minds and bodies, will we be able to tell whether we are doing any better at that than we have in the past as we go through the 1990s?

Do we have baseline data and can we measure it? Say in the year 1992, will we be able to look back and determine whether we are doing better or worse than in 1990?

Dr. **McGinnis**. Well, I can't speak to the education goals particularly, but I can speak to the health component of those education goals. Dr. Mason has placed as one of his highest priorities on the development of comprehensive school health programs. And, of course, that means working closely with our colleagues in the Department of Education about those elements that relate to school health education. And indeed we co-chair with the Department of Education an ad hoc Committee on School Health Activities.

Several of our objectives relate to the provision of comprehensive school health for virtually the entire population. I will read you an example from the one that you gave, that is in the nutrition arena: "Extend to all states required nutrition and education from preschool through K12 as a part of comprehensive school health education."

And we do have baseline data for that from our own surveys and from the American School Health Association. In another area, we have a target for improving the proportion of school lunch and breakfast services with menus consistent with the Dietary Guidelines for Americans. Unfortunately, we do not have baseline data for this, but we are working closely with the Department of Agriculture and we hope that once we gain agreement on a target that we can work collaboratively to develop the baseline data.

We will not include objectives in which we don't foresee some reasonable possibility of having baseline data for the purposes of this exercise.

Senator **Bingaman**. Let me refer to a letter that I received from Professor Dorothy Rice at the University of California, she wrote on March 12th. It says "I am writing to express my urgent concern regarding the totally inadequate proposed fiscal year 1991 President's budget for the National Center for Health Statistics, the Federal agency that has responsibility for collection, analysis and dissemination of statistics on the health of the Nation."

She then goes on to say that she is very concerned that the major survey, the National Health Interview Survey, may have to be eliminated for a year, and believes that doing so would be a major setback to our ability to track progress in some of these areas.

Dr. Feinleib, do you have a reaction as to whether her concern is founded or unfounded, or what is likely to happen there?

Dr. **Feinleib**. Yes, Mr. Chairman. We have not actually yet reached a decision on which surveys and to what extent each survey will be supported in fiscal year 1991. It is almost certain, however, that given current priorities for other programs, we are not going to receive the increases to the NCHS budget for fiscal year 1991 that would have been required to fund all of our desired activities.

As a result, we are reevaluating our survey plans. This reevaluation currently recognizes the important needs for data for the year 2000 objectives, and the priority needs for other data on the health of the American people and the health system. So no final decisions have been made on how we will best meet the overall needs for data within the resources available to NCHS. I do feel, however, that CDC and NCHS will take steps to ensure that the highest priority health data requirement will be supported in fiscal year 1991.

Senator **Bingaman**. My concern is that it seems we have on one hand an ambitious new set of goals and objectives that are being formulated, finalized and published to the country, and on the other hand we seem to be cutting back, or at least not following along with any kind of capability to measure progress toward those goals.

Am I missing something? There seems to be what they call in the Pentagon a mismatch of expectations and what is actually happening.

Dr. MASON. Mr. Chairman, you have identified a significant problem, and the problem is basically the same problem that most households face where aspirations outstrip resources, and so we have to set some priorities. And as Dr. Feinleib has said, we have not made a decision at this point in time, but we are having to make choices as to whether we will take from other schedules, other surveys that are scheduled, whether we will go back to other programs within CDC, whether we will look at other programs within the Public Health Service, or whether we will postpone the National Health Interview Survey for a year. These are the difficult decisions that we are faced with in the context of a finite budget. We are just trying to put the money where the priorities are the greatest.

Senator BINGAMAN. How many years have we done this survey?

Dr. MASON. The National Health Interview Survey?

Senator BINGAMAN. Yes, the National Health Interview Survey.

Dr. MASON. It was done in 1985. It is in the field now being done, but we wanted to do it again in 1991 to get baseline data for that 30 percent that you talked about where we didn't have good baseline data.

Dr. FEINLEIB. The survey has been going on since the late 1950s with the emphasis, besides the core survey, varying from year to year depending upon current priorities. But the last decade a large proportion of the effort has been devoted first to the 1990 objectives, and for the year 2000 we had planned to add supplements to track the year 2000.

Senator BINGAMAN. Okay. To what extent does the setting of these goals and the tracking of progress toward them provide information on what areas are the most cost effective in improving the health of Americans? Is it too much to hope for, that you could make judgments about what areas are the most cost effective based on how well we move toward achieving some of these objectives?

Dr. MASON. I think in the context of the greater responsibilities of the United States Public Health Service, each of the seven agencies have been given by the Executive Branch of Government and by Congress various responsibilities, and so all of the priority areas are already ongoing activities of the Public Health Service. In other words, we are not going to initiate, to my knowledge, anything new that isn't being done. All of these areas are considered by the Nation to be high priority areas.

There has been little attempt to try to distinguish, for example, tradeoffs between infant and child health versus our elderly population. I think in the United States we felt that we ought to serve the needs of both the elderly and the young. You can do those kinds of cost benefits. I think that as a Nation we have identified a number of health issues that are of consequence to the Nation, and the Public Health Service has statutory and other responsibilities to carry on activities in almost all of those areas that are covered by these areas.

What the year 2000 objectives do is provide a focus and a targeting so we can get the greatest bang for the buck.

Senator **Bingaman**. I am still a bit unsure. I understand what you are saying, but it seems to me that we have 21 priorities areas, and several hundred objectives, unless somebody comes out and says we are going to identify a very limited number of these and really work at them——

Dr. **Mason**. Okay. When we get down to a priority area and then the objectives under that, then I think this becomes a very useful basis to begin looking at which of those objectives are likely to be most cost effective.

Senator **Bingaman**. Okay. Dr. McGinnis, do you have anything to add?

Dr. **McGinnis**. Well, I think that is exactly right. The objectives process is I think quite useful in clarifying our opportunities. Indeed, that is one of the things that we heard back from the field when we set out to develop the process for the year 2000. An example, setting a target of 25 percent of adults in this country, no more than 25 percent smoking, indicates to us that we have to reduce the smoking rate from 35 percent to 25 percent over the course of a period of time. It was around 35 percent for males 10 years ago. If we are we can reach that target, we will be saving about 100,000 lives a year.

Now, that indicates the effectiveness of the program, it doesn't indicate necessarily the cost effectiveness. That is another consideration at hand. But by looking at the aggregate impact on society of some of the major problems that confront our Nation, we can get a sense of where our special opportunities lie, and the process affords that kind of an opportunity.

As Dr. Mason points out, the purpose of this process is really to give us a better sense within a given priority area of what the most important levers we have are. Even though there are, as you point out, over 300 target objectives scattered across the priority areas, we are talking about the potential operation of a very large public health establishment with participants with a variety of perspectives, and it is important that we address the perspectives of the broad range of potential participants.

Senator **Bingaman**. Okay. I am going to include a copy of this letter from Dr. Dorothy Rice in the hearing record.[1]

We may have additional questions that we want to ask of you folks as we go forward here. We want to work with you to try to make these objectives meaningful and understandable by the general public. I agree with Dr. McGinnis' comment that one of the unfortunate things about all the good work that has gone on to put this effort together is that the general public is largely unaware of the fact that we have national health goals. And they are health goals, they are not really health promotion goals. They are health goals.

But usually by virtue of the way news is reported we get a lot more attention to the triple by-pass liver transplant that is done in a hospital somewhere than we do to actual progress toward improving health in the country. I think you have the basis here for giving the American public very good information as to what the situation is on a regular basis, particularly what the situation is in those areas that individuals can take some responsibility for. I appreciate your testimony today. Thank you all very much.

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[1] See p. 208.

Our second panel will consist of Dr. John Mazzuchi, the Principal Director for Professional Affairs and Quality Assurance at the Department of Defense; Dr. James Heimbach, the Acting Administrator of the Human Nutrition Service at the Department of Agriculture; and Dr. Jane McDonald, Education Consultant at the American Association of School Administrators in Arlington, Virginia. Would all of you please come forward?

Why don't we just take you in the order I just read. Dr. Mazzuchi, do you want to go ahead with your testimony?

TESTIMONY OF JOHN F. MAZZUCHI, PH.D., PRINCIPAL DIRECTOR FOR PROFESSIONAL AFFAIRS AND QUALITY ASSURANCE, HEALTH AFFAIRS, DEPARTMENT OF DEFENSE [1]

Dr. MAZZUCHI. Thank you, Mr. Chairman. I will try to run through it fairly quickly in the interest of time.

I appreciate very much the opportunity to appear before this Subcommittee to discuss the Department of Defense's health promotion program and the proposed "Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation." I applaud your interest and dedication regarding issues related to our Nation's health promotion effort, and I want to acknowledge especially Senator your own role in helping the Department launch its health promotion initiative in 1986.

As requested, my testimony will address each of the questions raised in your letter of invitation to testify. Your first question asked whether the proposed objectives were valid, realistic and attainable. The proposed year 2000 objectives for the Nation provide a broader focus than those of the Department of Defense, but certainly one that is compatible with our health promotion efforts, and we believe that the objectives in this plan are indeed realistic, valid, and attainable.

In his first appearance before Congress as the Assistant Secretary of Defense for Health Affairs, Dr. Enrique Mendez stated that he will, and I quote, "Continue to advocate health promotion on the part of military personnel."

The Surgeons General of the Army, Navy and Air Force joined Dr. Mendez in expressing their personal commitment for health promotion and disease prevention efforts. These efforts were refocused and strengthened in 1986 with the publication of Department of Defense Directive 1010.10, which is entitled "Health Promotion." The directive reflected the recommendations of a special blue ribbon panel convened at the request of Congress to examine the Department's health promotion effort.

This directive established policy to encourage not only military personnel, but also their families and civilian employees, to live healthy lives through an integrated, coordinated and comprehensive health promotion program. The program focuses on six areas; nutrition, smoking, alcohol and drug abuse, stress management, physical fitness and early identification of high blood pressure. The overall program reflects the present objectives for the Nation and targets community, work site, internal mass media and clinical opportunities.

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[1] See p. 95 for Dr. Mazzuchi's prepared statement.

You also asked what would be required of the Federal Government as employer, insurer and health care provider to implement the recommendations that the report makes for private organizations. Government agencies can frame basic policies and programs for their employees that meet the spirit of these objectives, that promote a healthy lifestyle, and that assist in health risk reduction. There are a myriad of both Federal and private organizations from which to obtain both health education materials and services at a minimal cost. The role of Federal Government should be to make these resources both known and available to its employees and to create an atmosphere that is conducive to good health.

The Department of Defense health promotion policy applies to military personnel and to civilian employees. The department believes that the work site offers an effective opportunity for these two groups Our internal mass media resources disseminate health promotion information through multiple announcements in our press and publication service and radio and television spot announcements. The early identification of high blood pressure, for example, is a significant part of our health promotion program.

The Department of Defense actively supports National High Blood Pressure Month. Blood pressure screening is made available to civilian employees, not only through our occupational health clinics, but also through special health fairs, and to military personnel through the military medical and dental channels. Military communities often work with and take advantage of local resources to enhance the overall efforts. Cholesterol screening and smoking prevention and cessation programs are other examples of this effort.

Military health care personnel have been and will continue to be increasingly involved in health promotion issues. Our eligible beneficiaries rely on health care professionals for information and guidance and the health care system has been creative in designing mechanisms to meet the demand.

Adding preventive services to the Federal health insurance benefits should also be considered. The recent CHAMPUS Reform Initiative, which is known as the CRI, provides an excellent model. Within CRI, managed care plans offer preventive services. For example, enhanced benefits provided by the CHAMPUS prime program, which is similar to a health maintenance organization, include features such as periodic physical examinations, well child care for children beyond 2 years of age, wellness classes, discounts for special local services, and routine pap smears.

In addition, we believe that the Federal Government should examine the issue of linking its health insurance costs to lifestyle risks. Incorporating incentives in the Federal health insurance programs to reduce behavioral health risks would be cost effective in the long term.

You asked if there would be value in a national health "checkup." Most certainly an evaluation component is essential, although the need for an annual effort could be called into question. A periodic Department of Defense worldwide survey which was begun in 1980 provides an evaluation of the alcohol, drug and tobacco use trends of our personnel. In 1988 other life style health behaviors were added to the survey. The survey does not apply to family members of civilian employees.

The survey has been conducted every 2½ years and we are satisfied that this is the appropriate interval for measuring changes that result from our policy and programs. There are no plans to conduct the survey on an annual basis. The current national surveys, such as the National Health Interview Survey, do not identify military medical beneficiaries or Department of Defense civilian employees as a separate group, and consequently at present we do not have a mechanism to evaluate the health risk behaviors of our military families or our civilian employees, and it would be useful if these two groups could be pulled out of the existing survey sample.

Finally, you asked a question about whether or not additional resources are needed. Based on our current knowledge of our programs, we don't believe they are. However, a GAO survey initiated by Congress will focus on assessing the commitment of the Department of Defense to health promotion and disease prevention, and I believe that a more definitive answer to that question will be given when we see the results of that audit.

This concludes my brief testimony. I would be happy to answer any of your questions.

Senator **Bingaman**. Thank you very much. Let's hear from the other two witnesses before I ask any questions.

Dr. Heimbach, thank you for being here.

TESTIMONY OF JAMES T. HEIMBACH, PH.D., ACTING ADMINISTRATOR, HUMAN NUTRITION INFORMATION SERVICE, DEPARTMENT OF AGRICULTURE

Dr. **Heimbach**. Thank you, Mr. Chairman. I am pleased to be here today to discuss the Department of Agriculture's role in the year 2000 health objectives, and with your permission I would like to submit my full testimony for the record and abbreviate my remarks.[1]

Senator **Bingaman**. We will include it in its entirety.

Dr. **Heimbach**. We have participated in the development and review of the nutrition objectives specifically, and I would like to focus today upon our contribution to those objectives and USDA's resources that could be used to monitor progress toward the nutrition objectives.

The development of the objectives and their review has been a very open process. It has given opportunity for involvement by all interested parties. Extensive public input has been sought through public hearings, through non-Federal expert panel review, and broad dissemination of the draft objectives for public comment.

In participating in the development of these objectives, we have emphasized two areas. First is the need for the objectives to build on current programs delivered by the Federal Government. We believe that coordination between the objectives and the goals of Federal nutrition programs, whether research programs, education, food assistance or disease prevention programs, will strengthen the benefits to be realized by the public.

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[1] See p. 102.

Second, we have concentrated on assuring that all objectives and advice given to the public have a strong, well documented research base and that they are scientifically sound. This is essential for recommendations on the amounts of foods to consume, as well as for recommendations on the amounts of nutrients to consume.

The Dietary Guidelines for Americans, issued jointly by USDA and the Department of Health and Human Services in 1980, and again in revised form in 1985, are the statement of Federal nutrition policy. The year 2000 nutrition objectives are fully supportive of the concepts and the principles emphasized in the Dietary Guidelines. There are objectives that address the prevalence of overweight and the intake of fat, saturated fatty acids, sodium, complex carbohydrates, fiber and alcohol, all issues addressed in the dietary guidelines. The year 2000 objectives have been reviewed by the USDA and the HHS Executive Secretaries to the Dietary Guidelines Advisory Committee to assure comparability.

Turning to some of HNIS' nutrition education program, our Food Guide, developed in the early 1980s specifically to help people implement the Dietary Guidelines, specifies a recommended number of daily servings, for major food groups. The year 2000 objectives to increase intake of food sources of calcium, of complex carbohydrates and fiber, set goals for the population to attain daily servings of food groups that are the same as those in our food guide. The objectives for the year 2000 call for increasing the percent of the population consuming the recommended daily servings for dairy products, for fruits and vegetables, and for grain products.

Over the past year HNIS has released four new colorful booklets providing practical "how to" information that consumers need to put the Dietary Guidelines for Americans into practice in their daily food choices. This is a sample of one of these booklets which have been widely disseminated to information multipliers throughout the country. These have been the keystone of a campaign, "Eating Right the Dietary Guidelines Way," which was launched last July. This ongoing campaign is designed to increase awareness of the Dietary Guidelines for Americans and to help people put the Dietary Guidelines into action in their lives. Outreach is targeted to the public through the media and other information multipliers and through health and nutrition professionals in the public and private sectors.

We have sent full press kits to over 3,000 major newspapers and magazines, and smaller press kits containing reproducibles to over 3,000 smaller newspapers. Reproducibles are ones they can simply pick up and insert in their newspaper without the necessity of having on the staff a qualified nutrition writer. This gives us access to the public out of the major media markets. These efforts, and ones like them in the future, will play a major role in helping the Nation to reach the year 2000 nutrition objectives by the end of this century.

In some cases the objectives call for particular emphasis on special groups. We are also working on production of dietary guidance materials that focus on these needs. For example, we are adopting current dietary guidance materials for use with low literacy audiences. We are working with the National Institute on Aging to develop materials to help healthy older Americans, and we are working with the Association for the Advancement of Health Education to reach teens through the high school health education curriculum. This builds on a successful effort launched a couple of years ago that focused on home economics curricula.

There are a wide range of programs in U.S.D.A. beyond the Human Nutrition Information Service that contribute significantly to meeting the goals of the year 2000 objectives. Let me highlight two areas. Federal food assistance programs administered by the Food and Nutrition Service provide access to a more nutritious diet for persons with low incomes and encourage nutritious eating patterns among the Nation's children. Specifically, the Supplemental Food Program for Women, Infants and Children, the WIC program, is targeted at low income mothers and young children who are at nutritional risk.

The year 2000 objectives addressing iron deficiency, impaired growth, and breast feeding are fully in concert with the goals of the WIC program. This program provides participants with selected foods that are a good source of problem nutrients, including iron, and with nutrition education. It helps get low income pregnant women under medical supervision where problems, including those related to nutritional status, but also ones in some of the other priority areas, can be identified and treated. The WIC program encourages breast feeding, and it counsels mothers on its nutritional advantages.

The programs of the Extension Service and the Cooperative Extension System provide education and outreach in every county in the Nation. Improving health and nutrition have been identified as one of the priority program goals of the Extension Service. I would particularly like to mention the EFNEP, the Expanded Foods and Nutrition Education Program, which targets low income families, teaching them principles of nutrition and how to use limited food resources to improve their family's diet.

Now, let me turn back to the Human Nutrition Information Service and look at nutrition monitoring and surveillance. We are responsible for one of the 2 major components of the National Nutrition Monitoring System, a system of Nationwide Food Consumption Surveys, which includes the Continuing Survey of Food Intakes by Individuals. The Nationwide Food Consumption Survey is a decennial survey that provides data on 3-day food and nutrient intakes of individuals and information on foods used by households during a 7-day period, and the cost of those foods. It was last conducted in 1987–88, the previous survey had been in 1977–78. It will be conducted again in 1997–98.

The Continuing Survey has been designed to assess a nationally representative sample of the population on a continuous basis and is conducted every year. It collects food and nutrient intakes for all sex/age groups and reports results using a moving average approach that allows annual reporting. This approach is a cost effective means of providing trend information in a timely manner.

Both the decennial survey and the Continuing Survey include separate low income samples. These samples, compromising households with incomes at or below 130 percent of poverty, are of particular value for tracking progress of the low income population toward achieving the year 2000 objectives.

A new component of the Continuing Survey, the Diet/Health Knowledge Survey, assesses consumer knowledge and attitudes on diet health issues. The Diet/Health Knowledge Survey represents for the first time a nationwide sample being used to study the relationship between individuals' actual dietary intakes and their knowledge and attitudes about dietary behavior. These surveys provide data that can be used to monitor and assess progress toward many of the nutrition objectives. We have made some changes in the surveys to enhance their utility for this purpose.

Some specific examples of applications include self-reported height and weight data to determine prevalence of overweight; nutrient intake data of the population and in population subgroups to assess the intakes of specific nutrients that have been targeted; food intake data of the population and subgroups to assess consumption; food purchasing and preparation techniques; and use of food labels in making food selections.

The year 2000 nutrition objectives as drafted provide good coverage of the major nutrition issues in this country. Careful attention has been given to defining objectives that enhance and build upon the goals of existing Federal programs, specifically those which are designed to address the nutrition problems targeted in the objectives. Many of the goals are ambitious and will be a challenge. It will take the combined efforts at the Federal, State and local level, including health professionals as well as the business and industry community to meet this challenge.

The nutrition education programs of USDA that focus on the Dietary Guidelines for Americans will play an important role in meeting these challenges. The nutrition monitoring activities of the Human Nutrition Information Service will provide timely dietary data to assess how the country is doing in meeting these objectives over the next decade.

This concludes my formal remarks and I will be happy to answer any questions. Thank you.

Senator BINGAMAN. Thank you very much.

Dr. McDonald, why don't you go ahead.

TESTIMONY OF JANE A. McDONALD, PH.D., EDUCATIONAL CONSULTANT, AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS

Dr. McDONALD. Good morning, Mr. Chairman. Thank you for the opportunity to appear here today, and please allow my testimony that is written to be entered into the record.[1] However, I would like to highlight a few points.

Senator BINGAMAN. That's fine.

Dr. McDONALD. My remarks are organized around the four questions outlined in the Chairman's letter. Number one, are the objectives valid, realistic and attainable. Before I answer that I would like to say that what the Health Department is doing here is commendable, and this undertaking is an incredible thing to do, and taking leadership in this area is important and I commend them for that.

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[1] See p. 121.

I am going to be very candid about my remarks as far as the objectives go and how they relate to the general public. So are they valid, realistic and attainable? Yes, I think that they are realistic and attainable. I cannot speak to the validity of the assumptions that go behind the objectives. I think the basis here is good, the basis for building something very significant for our Nation. However, I have some reservations.

In general—you have mentioned this earlier, Mr. Chairman, the language and the content of the objectives seem to be expressed in language that is focused at health professionals and not at the general public. If these are to be national health objectives then it seems that the average person on the street in any part of our country should be aware of them and be able to state them, at least in broad terms. And there are quite a few of them, which will make that difficult. It seems like what has been put together already can be used as a basis for the evaluation of larger objectives or goals, and as I was listening to the gentlemen earlier it seems like they are aware of that themselves.

Some objections are not stringent enough for our 10-year time period, particularly the one that talks about comprehensive health programs in schools. We definitely should have 100 percent compliance in 10 years, rather than 50 as stated.

Some of the objectives talk about a goal or an outcome that is to be desired or reached, and yet there isn't information about how to do that. If you were the person on the street, again, it would be hard reading some of the language and then knowing what you were to do.

Only a few call for the training of parents, training of educators, and very few have to do with the collaboration of the agencies involved in this. It cannot just be the public school or just the Health Department, we are all in this together and there needs to be some collaboration.

One of the most important objectives is back in 20.14, and that is another concern I have about the objectives. They all seem to have equal weight. Therefore, the ones that might be the most important are not highlighted and could go unnoticed. This particular objective I am talking about is one that has the expectation for school districts to obtain comprehensive school health programs, and to me that is one of the most important because it is developing those early mental and physical attitudes, skills and habits for healthy living that will continue throughout our lifetimes.

Then number 2, what would be required for the Federal Government to encourage the attainment of the objectives that apply to educational institutions? There are three things. One, funding. Health programs usually take a back seat to other programs in school districts, and categorical grants are sometimes available and definitely have helped, like in HIV infection programs, alcohol abuse. Those are certainly helpful. But categorical grants tend to fragment a total comprehensive program of health education in the schools. So although the categorical grants are needed and appreciated, additional funding that can be used at the discretion of the school district to help with the needs that are specific there to develop a comprehensive program, to be innovative, and to extend the exemplary programs that are already out there, the flexible use funding is extremely important.

Approximately eighty percent of a school budget goes for salaries, and I am not sure the general public understands how little money is left to carry out programs. I remember as an assistant superintendent, we would announce to the public, well, we spend this amount of money on each child. But what that includes is the salary of teachers. When you get right down to what is being spent on the actual instruction, and not on construction of schools, not on transportation, not on salaries, not on the fixed costs, is very small. So the funding is extremely important, particularly to develop a comprehensive ongoing program so that we can really make an impact.

Legislation is the area that is extremely important to schools, particularly in the area of alcohol. Alcohol is a number one health problem in schools across the Nation. Alcohol related traffic crashes are the leading cause of death and spinal cord injury for young Americans. The advertisement on television of beer, wine and wine coolers is linked to sex, fun, sports, friends and lifestyles that couldn't get any better. And Congress needs to bite that bullet and act to legislate the removal of all alcoholic products from the media. It has been done with cigarettes. Alcohol, again, is our number one health problem in schools.

Legislation would be extremely important to curb or eliminate alcohol advertising on television, because the media, of course, is so much more powerful than what happens in classrooms on a face-to-face basis sometimes.

The third area that is needed is publicity. People on the street need to know the national health objectives. The students in the schools need to know the objectives. And money will be well spent on, and I call it a Madison Avenue approach, which has to do with a real slick advertisement campaign that relates to students of all ages and to people of all ages. Someone that really knows what they are doing. So often those of us in education are not always the PR people or the publicity people that those in the profession of publicity are. So our own reports, like the one you are talking about, which is a checkup of the Nation, will continually bring this information in front of the public. I think once the awareness occurs among the American people, then some action will follow.

The number 3 question, would there be value in an annual national checkup to show the status of the objectives? Yes, there would be value in that. I would hope you would ask: what is the purpose of the checkup, what kind of data are you going to collect? And it seems from your comments this morning that is exactly what you will be asking. What follow-up will take place? How will this effort of the checkup make a difference in changing the quality of lives for Americans? And will funds be available for follow-up action.

It has been mentioned before but it is extremely important that the data collected reflect state and local health—the health status of state and local areas, not just national. For instance, one location in the country, as you know, could have a high alcoholism rate, another one could have a high cancer rate. If you aggregate the data, well, it would be neutralized as it goes across the Nation and would appear as though there weren't the problems that really do exist. The objectives must be personalized, and as long as we can bring them down to that person in the classroom, the person on the street, then an annual checkup or every two years checkup or whatever you have in mind would be appropriate.

Number 4, are there additional resources that are necessary to adequately monitor and reach the objectives? My response to this question is reflected in number 2. My recommendation to the Subcommittee is to establish focus groups across the country to address this question. The Subcommittee might ask students, teachers, curriculum specialists, certified health educators and other appropriate individuals. In other words, the people who are involved at the implementation level. Those are the people who need to be involved to give you additional information.

And then I added a fifth question, and it has to do with superintendents across the country who have exemplary health education programs, and their suggestions for promoting and implementing effective health education programs in school districts. This is appropriate here because some of their suggestions are also suggestions that could be used in implementing the national health objectives.

One of the suggestions is that we must confront and examine competing value systems with legislators and local community members. For instance, if we say that mental health is important and yet we still have the attitude out there that if someone does seek counseling that they are crazy, that is competing value systems. The tax base in some of the school districts comes from the wine and tobacco industry. I am sure you experience this in the political arena. And yet we are saying that alcohol and cigarettes are extremely dangerous to our health. Again, that is a competing value. So we have to confront those values. It will not be easy, it causes controversy, and yet if everyone is happy, then perhaps we aren't doing the things that we need to do for the health of our Nation.

Superintendents also suggest since alcohol is the number one health issue in schools, that we speak out against alcohol advertising in the media and similar exploitations of youth in the media.

They say establish partnerships with other agencies and organizations to work for the total child. Often in school what happens is we have social services saying here is a child with a particular problem. We have another agency, the Health Department, saying well, this child has a particular problem. In schools we might say this child has an instructional problem, learning problem. And it looks like there are 3 different children when actually it is just one child with many problems, and they all overlap and we need to collaborate our efforts and join in partnerships with other agencies.

We need to devise a plan for dealing with vested interest groups, which I spoke about earlier. Also, we need to obtain health funding that allows for flexible use in school health programs, conduct ongoing staff development activities and health education for teachers, administrators and support workers, and develop a strong parent component in training and implementing the health objectives.

The superintendents with exemplary health programs all say that what is needed in their districts, if they don't already have them, are health assistance programs, employee assistant programs, because they say: first begin with yourself and get interested in health for yourself. Then that relates to children and how you teach children, and then put health issues into the curriculum as a total health program. I would say that is generally true of these health objectives. The most excited and committed people of these health objectives for the year 2000 are those who are healthy themselves and are into that kind of mind set.

A few more comments by the superintendents: Get the teaching and administrative staff to personally buy in. That's how we make a difference in the schools. And be accountable. Those school systems with exemplary programs want to be accountable and are. They know what they are going for. They evaluate, they monitor, they adjust. They have their goals and their objectives. Superintendents also said to encourage and reward risk taking for innovation in program design, implementation and evaluation. What does not work is valuable information, and too often we will not allow failures. We learn a great deal sometimes from things that don't work.

And then the last thing that superintendents said is to communicate often the health vision so that everyone is aware of it. And this, of course, is something we must do with the national health objectives. Communicate the vision that we have over and over until people are committed to doing something personally and for others.

So in conclusion, lifestyle is now recognized as the major determinant of health and we all need basic knowledge, skills and attitudes if we are to make wise decisions about health. But it is especially important to teach children and young adults about this subject. Comprehensive health education programs in school districts can provide the most appropriate, systematic, efficient, and I might say cost effective, means available to enable young people to develop healthy attitudes and habits and avoid health risks. Schools cannot do the job alone. Collaboration of agencies, appropriate funding, proper legislative action and publicity are vital components to quality promotion and attainment of the Nation's health objectives for the year 2000. Changing attitudes is much more difficult than fine tuning a skill. It is ongoing, it is time consuming, it takes money, it takes commitment, it takes priority, and it takes continual working at it. It also takes courage on the part of those of us who must confront controversial issues.

I thank you again for the opportunity to be here and will be happy to answer any questions that you might have.

Senator **Bingaman**. Thank you very much. I appreciate your testimony.

Dr. Mazzuchi, let me ask first of all, does the Department of Defense have updated good information on where you stand on some of these health objectives? For example, one of the objectives related to tobacco use is to reduce cigarette smoking to a prevalence of no more than 15 percent among people age 20 and older.

Do you have good information as to what the percentage is today in the military?

Dr. MAZZUCHI. Yes, sir, we do. The worldwide survey that I talked about gives us measures of use patterns in three areas, alcohol, illicit drugs, and smoking. It also gives us measures, baseline data in terms of attitudes and knowledge about HIV-AIDS, and in terms of certain health behaviors such as exercise, knowledge of nutrition, et cetera.

In the smoking area, the anti-smoking campaign that was launched in 1986 by then Secretary Weinberger called for reducing smoking in the military by 10 percent. The 1980 figure of current smokers in the Department of Defense was 51 percent, an extremely high rate. The 1988 survey rate is down to 41 percent. We will continue to track that.

Our view is that both our heavy drinking rate and our smoking rate in the military are markedly higher than in the civilian community and we are looking very closely at those rates. The survey that I mentioned will be repeated in 1991 and we are looking forward to seeing that analysis.

Senator BINGAMAN. Is there a strategy in place to try to get from where you are today, say the 41 percent figure, down to this national goal by the year 2000?

Dr. MAZZUCHI. Yes, there is, although I think the strategy can be improved. We participated in a meeting with the American Cancer Society which talked about the need for refining our strategy. The original strategy as announced by the Department in 1986 was a special effort to reduce the smoking rates of the new people coming in. Our survey data indicated very clearly that people came to the military with smoking rates similar to or lower than the American population as a total group, and yet, within a year or so after being in the military, their rates were considerably higher, which meant that people were picking up the habit of smoking by being in the military.

So our first educational campaign was focused primarily at recruits and at changing organizational behavior that would have encouraged smoking, dealing with things such as take a smoking break and so forth, try to get rid of those types of behaviors and trying to create an atmosphere where not smoking was the norm in the Department, something we have achieved.

Our next effort has to be retargeted towards our primary health care providers, in getting them to be much more confrontive with the smoking issue in all of the interventions in our health care system, and we have to continue working to make sure that people coming into the military recognize not only the health hazards of smoking, but the incompatibility of smoking cigarettes, particularly, and the use of chewing tobacco, with military life because of its negative effect on physical fitness, which is so important to us.

Senator BINGAMAN. Do you have any good epidemiological studies about former military personnel and the effects on later health of some of these health habits that seem to be acquired early in this military career?

Dr. Mazzuchi. Well, it depends on how you are looking at it. We do have some good data, again, on smoking and also alcohol and drug use. Basically, there are studies that have been ongoing for awhile on people coming in, in basic training or shortly thereafter, and then following that cohort. We have found, for instance, in the middle 1980s in some of these surveys that illicit drug use was a pattern of behavior brought into the service by people coming into the military, reflecting probably patterns developed during high school days, whereas the smoking behavior was one that was clearly picked up in the military.

My own personal view is that there are organizational factors that certainly encourage smoking in the military. The classic example is encouraging smoking breaks as a form of relaxation, but certainly the cost of tobacco products in the military is markedly cheaper. That is an organizational yes, as far as I am concerned, about smoking.

Senator Bingaman. Is that something that DOD is going to do something about? I have proposed now for several years that that problem be rectified by increasing the cost of tobacco products sold on military facilities to the level that it is in the civilian world. To no avail unfortunately. We haven't been able to get the votes here in Congress to do it. I thought at one point DOD was going to become enlightened and do it itself. You clearly have the authority to do so, but there has been no effort to, or no visible sign of progress. Is there likely to be?

Dr. Mazzuchi. Well, from the health community, which I represent, both then Assistant Secretary Mayer, and Dr. Mendez, the new Assistant Secretary, believe that the pricing policy encourages smoking, and therefore oppose that policy. But as you know, there are more components than just health in the Department of Defense, and that view is not shared, especially by those people who run commissaries. We certainly will continue to work on that issue. We continue to look at the status of smoking in the military. As long as the smoking rates remain as high as they are, I think it is incumbent upon the Department to look at every possible strategy to reduce the smoking rates to achieve those goals set by the year 2000 goals. And pricing will have to be one of those things that is looked at by the Department.

Senator Bingaman. Would it be reasonable for Congress to request that DOD give us a written plan for how it plans to achieve the year 2000 goals as it affects people in the Defense Department?

Dr. Mazzuchi. There are many goals and objectives, but I certainly think it would be reasonable to do that, particularly if the focus were primarily on the smoking and alcohol objectives. The Department is already working both with the people at the Public Health Service and internally to try to take each of the goals and objectives and look at them as they apply to the Department of Defense's particular population. There are some goals and objectives, for instance, where we are markedly ahead of the Nation and some where we are markedly behind the Nation. It is our intention to do that anyway. Consequently, a request from the Congress may add impetus to doing it.

Senator **Bingaman**. All right. Thank you. Dr. Heimbach, your primary focus in your testimony has been on the issue of nutrition, which would seem natural. Are there any other areas of these goals that the Department of Agriculture sees itself as having a significant responsibility for? In your health education or other programs, do you just focus on nutrition, or do you do anything else?

Dr. **Heimbach**. Nutrition is certainly the primary emphasis, particularly of the Human Nutrition Information Service. Now, such programs as the WIC program, for example, which encourages bringing pregnant women under medical supervision, certainly get well beyond nutritional problems alone. Similarly, USDA as a model employer, if you will, has responsibilities that go beyond the nutrition area. But certainly the focus of our activities as they relate to the year 2000 health objectives is with the nutrition objectives.

Senator **Bingaman**. So in none of your educational materials do you get into such issues as smoking or any of those things?

Dr. **Heimbach**. No, we do not deal directly with smoking in the educational materials we put out. Now clearly, some of the objectives in other areas such as heart disease and cancer have dietary links and consequently we relate to them through our nutritional responsibilities.

Senator **Bingaman**. Regarding your nutritional responsibilities as they are interpreted by you, how do those play out in the meeting of some of these nutrition goals? There is one here on public awareness. One of the goals, 1.14, says "Increase to at least 90 percent the proportion of people age 12 and older who can identify the principal dietary factors that are associated with heart disease, hypertension, cancer and osteoporosis."

Do you see what you are doing as only contributing to that? Who would be the primary Federal agency with responsibility to reach that goal, or is there one?

Dr. **Heimbach**. As that one is listed there are several responsible agencies, but we do work with them. For example, one of the areas that you mentioned had to do with high blood cholesterol and coronary heart disease. A primary Federal effort to focus on raising the awareness of the public of the factors related to heart disease is the National Cholesterol Education Program. Now, that is principally organized in the National Institutes of Health, in NHLBI. On the other hand, USDA does have a liaison membership in the Coordinating Committee for that program.

We have been very intimately involved in working with the National Cholesterol Education Program not only in setting objectives for the program, but in refining those objectives, in determining the path to reach those objectives, and in providing information relevant to monitoring progress towards those objectives.

Senator **Bingaman**. You folks at USDA have a large part in the school lunch program. Do you have any kind of nutrition educational component as part of that?

Dr. **Heimbach**. The school lunch program itself per se? There is some material that is provided with it. I cannot tell you exactly what. I will be happy to provide you more information for the record with regard to what information goes to that. There is an educational component certainly for the school food service people themselves. I will provide you any information that may be directed toward the children related to that.

Senator **Bingaman**. Do you have a separate activity that is focused on school children that relates to nutrition education?

Dr. **Heimbach**. We have a number of them. As I mentioned, one of the materials that we are developing, for example, is a nutritional teaching kit that is adapted for use in health classes in the schools. We already have in place one that is incorporated in home economics classes in the classrooms. We have developed some other materials that are specifically targeted towards schools. For example, we have the USDA's Dietary Analysis Program. It is a little computer program that you can enter what foods you have eaten over the previous day or the previous 3 days and it will come back with a report on how your diet compares with recommendations by authoritative groups. The program is available to the schools.

[Further information submitted by Dr. Heimbach follows:]

The Nutrition Education and Training Program (NET) was established by Congress to serve as the educational component of the Child Nutrition Programs, which include the National School Lunch Program, the School Breakfast Program, the Child Care Food Program, and the Summer Food Service Program for Children. First authorized by an amendment to the Child Nutrition Act under Public Law 95-166, November 10, 1977, NET was reauthorized under Public Law 101-147, November 10, 1989 through Fiscal Year 1994.

The NET Program aims to help build good food habits by teaching the fundamentals of nutrition to children, parents, educators, and school food service personnel. All children, teachers and food service personnel in public and private nonprofit schools and child care institutions eligible to participate in the Child Nutrition Programs are eligible.

An ongoing needs assessment in each State serves as the basis for development of the annual State plan for NET operations, which include training and instructional activities to reach school food service personnel, teachers and students. Activities in any State may vary from year to year, addressing top priorities to make the best use of the funds available. Over a period of years all target groups are reached through appropriate activities. These activities range from inservice workshops and college level courses for school food service personnel and teachers to an illustrated booklet on recognizing good foods for preschool children or sequential curriculum materials for students from grades K-12.

Senator **Bingaman**. Could you just tell me the status of the surplus food distribution activities of USDA? It is off the subject of this hearing, but I continue to get questions about it as I travel around my state.

Dr. **Heimbach**. I am afraid it is also off the subject of my expertise, but I will be happy to get that information and provide it for the record.

Senator **Bingaman**. Okay. I would appreciate that.

[The information submitted by Dr. Heimbach follows:]

Cheese, rice, and nonfat dry milk are no longer being distributed through the Temporary Emergency Food Assistance program (TEFAP) because surplus stocks of these products have been depleted due to the significant amount of these commodities which have been distributed and the changes in agricultural price-support programs and market conditions. The Department is, however, continuing to make flour, cornmeal, honey, and butter available. In addition, the Department purchased an additional $120 million worth of commodities for distribution through TEFAP in accordance with the Hunger Prevention Act of 1988. The additional commodities currently being made available are canned pork, peanut butter, raisins, canned green beans, and canned vegetarian beans.

The Temporary Emergency Food Assistance Program and the Department's authority to purchase an additional $120 million worth of commodities expire in Fiscal

Year 1990. The Administration supports reauthorization of these provisions through Fiscal Year 1995.

Senator **Bingaman**. Dr. McDonald, I have some questions about some of the issues related to health education. At the present time, do you see any kind of coordinated program to reach the kinds of goals that we have set for health education? I favor going forward with implementing a comprehensive school health education curriculum in our schools, but it seems to me that the Department of Education isn't very interested in the subject.

There may be a few states that are doing what ought to be done, but most of them I think are giving this pretty short shrift considering the other demands being made on them.

Do you see any real national leadership out of any institution on this subject?

Dr. **McDonald**. Possibly the only one that I am aware of is coming out of the Health Department right now. The Health Department has awarded grants to several agencies to target specific citizens, like schools is one, elderly, people at risk, these kinds of things. And the American Association of School Administrators has been awarded the grant that targets schools. So the collaboration of all of these people together through the Health Department's efforts may be a first in that area.

What the schools naturally do is try to bring everyone together. I mean everything eventually ends up in our laps. And in our grant we are going to have 400 executive educators across the country meet in New Orleans this spring, and one of the things that we will do is to introduce the objectives to them, at least the ones we have, and then introduce some of the other Federal agencies and state agencies and national organizations that can help schools reach those goals. We will bring them to this conference presentations by them and booths available and so on.

Senator **Bingaman**. I thought that the concern about the drug epidemic would be an impetus or an opportunity for the promotion or the dissemination of more comprehensive school health education activity. As part of educating children about the dangers of drugs you could also educate them about the dangers of other types of things and raise their awareness of health related risks.

Has that happened in many states? Are there programs that are focused on reducing drug usage which also get at some of these other health related issues?

Dr. **McDonald**. Probably through categorical grants, there is an emphasis. And, of course, school districts themselves can choose to have programs like that. I was a former high school principal as well as assistant superintendent, and as principal we organized the student Government and the other students in our school and the teachers to do some things. So it really is left to do where you can, and what is important to the people involved, if it is a priority.

Senator **Bingaman**. But we would need some kind of significant commitment by the U.S. Department of Education if this kind of comprehensive school health activity were really to become a national priority, as is proposed in these goals; is that a fair assumption?

Dr. **McDonald**. I would hope that they would be committed to it. I firmly believe, however, that we can operate, if need be, without them. Of course, it would not be as healthy or as desirable, but schools are going to do it anyway. Schools are going to go ahead with what the needs are for their children and for their communities. So whether the Education Department is backing it or not, it is still going to happen. However, a coordinated effort and commitment is valuable.

Senator **Bingaman**. All right. Well, thank you all very much. I appreciate your taking time today to testify here.

We have one additional witness. Mr. Garland Land, who is the Interim Deputy Director of the Department of Health with the State of Missouri is here. Would you come forward please Mr. Land.

Thank you for being here. Go right ahead and summarize your testimony, and we will include it all in the hearing record.

Please go ahead and make whatever points you would like.

TESTIMONY OF GARLAND LAND, INTERIM DEPUTY DIRECTOR, DEPARTMENT OF HEALTH, STATE OF MISSOURI

Mr. **Land**. Thank you. I am Garland Land, Interim Deputy Director of the Missouri Department of Health. Charlie Stokes, who is the Interim Director for the Department, has asked me to testify on his behalf for the Association of State and Territorial Health Officials.[1] I personally served on one of the work groups which is developing the year 2000 health objectives, and I also serve on the Model Standards Committee. I would like to discuss both of these projects, and also how the health objectives 2000 act will assist in accomplishing the year 2000 objectives.

First I will respond to the questions posed by you in your invitation to testify. The first question, are the objectives valid and measurable? From the beginning of the process there has been a strong intent to make the year 2000 objectives valid and measurable. It has already been mentioned that that process has been lengthy and has allowed for a variety of input from health professionals throughout the Nation.

In some areas, however, information is not as complete as it needs to be to measure the objectives. The year 2000 project is identifying areas of inadequate information and has a specific work group assigned to identify and prioritize information needs so that these information resources can be developed during the next decade.

If I might, I would like to digress from the written testimony. I am distressed to learn today that there is a possibility that the Health Interview Survey will not be conducted in the future because of a lack of resources for the National Center for Health Statistics. We need to be developing new data systems to fill the data gaps revealed through the year 2000 objective setting process. Disbanding data systems will be a major set back for the Nation. The Health Interview Survey provides data for one-fourth of the 2000 objectives. If this important survey is not funded, measuring the year 2000 objectives will be seriously compromised.

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[1] See p. 127 for Mr. Stoke's prepared statement.

The second question, what is the relationship between these objectives and the model standards project? Originally both projects were undertaken about the same time over a decade ago, and for similar reasons. But they are separate documents. Over the past decade as States and localities have attempted to integrate them into local planning activities, it became apparent that they were not entirely compatible. The Institute of Medicine held hearings across the Nation to solicit testimony in preparation for developing national year 2000 objectives. Many who testified had attempted to use both documents in State or local planning, but found the two documents confusing when used together.

The differences between the two documents from overall structure to the wording of individual objective statements were significant enough to make implementation very difficult. It was strongly urged that both documents be revised to be complementary. From the Institute of Medicine report, "The objectives for the Nation address the question of what it is we want to achieve. Model standards is presented in a format which addresses how we are going to achieve these goals. The objectives for the Nation are designed to reflect national goals. However, most national objectives can only be achieved if local communities work to accomplish them. Model standards are an effective tool for assisting local communities to establish appropriate and attainable objectives."

The model standards were constructed in a fill-in-the-blank format, so that localities can insert their own data and target dates. With the formats constructed in different styles and for different audiences, the two documents were not completely compatible. In revising these documents to focus on the year 2000, both workgroups—that is, the year 2000 and the Model Standards Committee—have agreed to combine their separate documents into an integrated structure. The objectives and model standards will be published in two volumes of the year 2000 objectives for the Nation. The objectives workgroup will establish the national objectives, the model standards workgroup will expand the national objectives into a workgroup that can be utilized for planning at the community level.

The third question, does development of a nationwide plan and report have meaning on a State and local level? The answer very simply is yes. Many States, including Missouri, responded to the 1990 objectives by developing their own versions based upon State level data. At the local level these documents can be used in the same way. The model standards, in fact, are designed for use at the local level in community-based planning for health programs and services. With their fill-in-the-blank format, local communities can select and personalize those objectives that are most pertinent to their own situations.

However, States do not always have State level data to match the national data. The quality of State data and the ability to analyze the information varies depending upon the amount of resources each state is able to put into the database development. Vital statistics and communicable disease data are available in all States, but there is a wide disparity among the States regarding the availability of other needed information.

The Institute of Medicine report, "The Future of Public Health," cited data development as one of the infrastructure issues that has been poorly supported over the years and that has significantly hampered States' ability to respond to health threats in the population. The health objectives 2000 act is a proposal designed to confront these weaknesses by providing States with resources to strengthen the public health infrastructure and directly address the goals of the year 2000 objectives.

Each State under the act would receive a block grant to specifically implement their selection of the year 2000 objectives. It requires each State to submit a plan and report progress toward the plan on an annual basis. This information would be compiled for Congress' information by the Department of Health and Human Services, thereby tracking national progress toward the objectives. These funds would not only cover program expenses, but also provide resources to develop the missing databases and information sources needed to identify needs and track progress at the local and State level.

However, we have a concern over the level of authorization attached to the bill. In its original version, the bill set aside $1 billion to divide among the States for implementation of the year 2000 objectives. Since that time the authorization has been cut to 300 million, and the entire public health block grant, currently funded at $89 million, has been folded into that total. Since programs are rarely funded at the full authorization level, the bill in its current form may not significantly improve the State's ability to respond effectively to national health objectives.

We would like to see the authorization level restored to the $1 billion level. In Missouri alone we will be spending slightly over $1 billion in our Medicaid budget for fiscal 1991. Missouri's portion under the $1 billion authorization level would be approximately 20 million, or just 2 percent of Medicaid expenditure. In contrast to the high cost of medical care, we are talking about a relatively small investment to curtail some of the illness and injury that lead to expensive treatment.

In conclusion, the year 2000 objectives and model standards are both useful and necessary to the States. In the present approach they provide both a unifying vision and the tombs with which to achieve that vision. States already have a track record in their attempts to use past documents in planning and programming. With availability of resources targeting national objectives, the states are ready and willing to do more. Progress toward achieving the objectives has been impaired by the lack of resources to implement this type of planning and to build the information sources States and local communities require for assessing needs and evaluating progress. The health objectives 2000 act would provide the needed resources and help to focus our efforts to achieve significant gains in the health status of our citizens.

Thank you very much for the opportunity to testify. We believe in this effort and we are gratified to know that you are both interested and supportive.

Senator BINGAMAN. Thank you very much. Let me say first of all that I certainly support this health objectives 2000 act and hope that we can have success with it this year.

If the National Health Interview Survey were not conducted this year, what would be the impact on a State such as yours? Would you have to try to develop your own data along those lines, or would you just do without it? What would you do?

Mr. LAND. I think the impact is multifold. First, it is a great impact on the year 2000 process, as I just mentioned. One-fourth of the objectives relate to that survey, and if we don't have that survey we don't have the baseline information to measure where we are coming from for the next decade. So that's of major concern, besides all the other uses that we have on a national basis for that data.

On the State level, because States do not have that type of information, typically they will use the national database to make estimates of what the health effects are in their local area. Those types of surveys are very expensive surveys, they are very complex surveys, and most States do not have the resources to conduct them. So we are very dependent upon the national surveys for local information.

Senator BINGAMAN. When you get down to the specific objectives that are contained in the draft that is being circulated, how does a State such as yours decide which of those objectives deserve more attention than others? Or when you can't do all 300, or you can't try to pursue all 300 in a very meaningful way, how do you make the decision as to which of them to pursue, and how realistic is it for us in Congress to expect that a State would make that decision and in doing so make the right decision and pursue it consistently long enough to have an impact?

Mr. LAND. In Missouri, when the 1990 objectives came out we reviewed those, and through our staff in the Department of Health and through consultation with outside organizations, medical, osteopathic, hospital, public health, and so forth, we boiled down the year 2000 objectives to 13 goals for Missouri for the decade of the 1990s.

Now, individual programs may still track the lesser objectives for their own purposes and try to work on those, but we tried to develop a document, that you were referring to earlier, that would be more user friendly to the public, that we could show to our legislature and to the public when we were meeting with them. This is where we are going as a health department, a very concise document.

I would expect that we would do a similar type of thing for this next decade, that we will boil that document down to a very manageable number, still track the others on a program specific basis for internal program management, but we need to have some type of public document that we can use to relate to our legislature and to the general public.

Senator BINGAMAN. You did this for reaching the 1990 goals and you are now to that point. Are you in a position to report progress as to how well the State did in meeting the goals that were set?

Mr. LAND. We are in the process of doing that, of revising those. Actually, the process that we went through was really looking at the year 2000. So we are going to be revising our 2000 objectives now in light of the national objectives to conform to the national objections. But every year we review where we stand and develop a document that identifies those that we have already attained in some areas. We are actually ahead of schedule in some, and some, just like at the national level, we are behind and we are still working on.

Senator BINGAMAN. Does your review and your monitoring of progress in these areas actually impact on where the State puts its resources in trying to improve health?

Mr. LAND. It definitely does.

Senator BINGAMAN. Could you give me any examples of programs that you have beefed up because of information you received while going through this process?

Mr. LAND. One of the objectives that we had was to develop an injury control program in the State of Missouri. We had some objectives that related to trauma centers, that related to head and spinal cord injury prevention, that related to homicides and so forth. Those types of activities had never been promoted in our State in the past. That was a whole new area for us.

With setting that as a major goal for the department, we passed legislation 2 years ago, our legislature passed legislation through our encouragement, to develop a trauma center system. We were able to get funding from the Centers for Disease Control to develop an injury control program. We have identified black homicides in St. Louis City as being a major health problem, because at the time we did this study they had the highest black homicide rate in the Nation. There is now going to be a conference in St. Louis in the fall of this year through the mayor's support, because of the study that we developed, to respond to that as a public health issue. So that document is indeed driving us in new areas that we had not been into before.

Senator BINGAMAN. All right. Well, I appreciate your testimony today very much. I think it is very useful and gives us a good perspective on how the States are trying to grapple with some of these problems. Thank you very much for being here.

We have one more hearing on the same set of issues, which is scheduled for April 6. At that time we will hear additional testimony on what we need to do to support the very useful effort to set national goals and track progress toward them.

Thank you all for being here and the hearing is adjourned.

[Whereupon, at 11:40 a.m., the hearing was adjourned, subject to the call of the Chair.]

QUALITY OF U.S. HEALTH STATISTICS AND TO REVIEW THE YEAR 2000 OBJECTIVES

FRIDAY, APRIL 6, 1990

U.S. Senate,
Subcommittee on Government Information
and Regulation,
Committee on Governmental Affairs,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:30 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Jeff Bingaman, Chairman of the Subcommittee, presiding.

Present: Senator Bingaman.

Staff present: Edwin S. Jayne, Staff Director; Robert Moore, Legislative Fellow; Elizabeth Powell, Detailee; Ann Schnittker, Staff Assistant; and Richard Ashooh, Minority Professional Staff Member.

OPENING STATEMENT OF SENATOR BINGAMAN

Senator Bingaman. The hearing will come to order.

This is the second of two hearings that the Governmental Affairs Subcommittee on Government Information and Regulation has scheduled on the Federal Government's ability to gather, maintain and assess statistics related to health promotion efforts and health. In particular, I hope to review our current statistical gathering efforts in the context of the Public Health Service's Year 2000 Objectives for promoting good health and preventing disease.

On March 20 the Subcommittee heard representatives from the Department of Health and Human Services discuss the current draft of the Year 2000 Objectives. At the hearing we learned that although a fundamental part of the objectives is measurability, funding for the National Center for Health Statistics, which is the Federal Government's chief health statistics gathering entity, might not be sufficient to establish baseline data for many of the objectives. While no final decision has yet been made, the Department might not conduct the 1991 National Health Interview Survey, which has been conducted annually since 1957. These surveys have been a vital part of the health policy planning at both the state and national levels and in the future could be very useful in helping to chart our progress toward the Year 2000 Objectives.

I think everyone would agree that we need to establish a baseline of our national health status now at the beginning of the Year 2000 project. If we have those baselines, changes in our national condition could be noted and intervention strategies implemented. Growth in the incidence of any particular disease could be revealed and, if found in time, might be correctable. An annual checkup could give us early warnings of problem areas and would give individuals the data and information they need to encourage local and state health departments and the Federal Government to diagnose the problem and affect a cure.

I do not mean to suggest that we are making no progress in the fields of health promotion and disease prevention. In fact, the opposite is true, but I believe we could do much more. Without question, wonderful scientific advances have been made in this century, which explains much about the nature of health and disease, and our medical establishment is far better trained than in the past. I often wonder whether we are concentrating our efforts too much on research and health care rather than on prevention and education, which could have a significant—and cost effective—impact on the Nation's health status.

In many areas I think we need to reconsider our health strategies. For example, we lose far too many babies in their first 12 months of life—10.4 per 1,000 live births in 1986—making the U.S. 22d among the industrialized nations behind Japan, 5.2; Hong Kong, 7.7; Canada, 7.9; Spain, 8.5; Ireland, 8.7; East Germany, 9.2; Singapore, 9.3; Italy, 9.8; among others.

In terms of life expectancy, the United States also lags behind other countries. Men live longer in 19 countries—led by Japan with a life expectancy of 75.5 years—and women live longer in 14 countries—led by Japan with an average life expectancy of 81.6 years. While improvement has been made, much remains to be done.

The incidence of death from some diseases is growing in the United States. We would expect that deaths from AIDS have increased because the disease has only been identified within the past decade, but we would not expect that same result with other diseases which were identified many years ago. Respiratory system cancer has tripled, from 12.8 cases per 100,000 resident population in 1950, to 39.7 cases per 100,000 in 1987. This disease now kills women at more than 5 times the rate it did in 1950. Many diseases strike minorities disproportionately, and research must be done to determine the reasons. One of the Public Health Service's year 2000 goals is to reduce the difference in life expectancy between white and minority populations to no more than 4 years. This is possible and needs to be done.

The health and social problems brought on by improper or inadequate early health care can plague us for years. Heavy smoking, drinking, or drug use during pregnancy can result in low birth weight, premature babies. We need to learn more about the later health problems of these children, and we need to learn of ways to break the cycle of poverty, addiction, despair and poverty. We applaud the actions of organizations like the Eleonore Hutzel Recovery Center in Detroit, Michigan, which is willing to care for pregnant addicts. The Hutzel Center provides prenatal, delivery and postnatal care to women experiencing high risk pregnancies and tries to persuade mothers to enter day or residential treatment for their drug dependencies. We need more centers like this throughout the country.

A bill, introduced by Senator Tom Harkin, could help States address many of these issues. This bill, which is S. 2056, would provide grants for States to establish and implement State health objectives related to the national objectives. This bill is an excellent vehicle to enable States to participate in the national objectives and to concentrate their efforts on meeting their selected objectives.

We are going to include testimony from Senator Harkin in the record in explanation and support of his bill. He was unable to be here today to testify on it.[1]

We look forward to the testimony of the three panels that we have today. The first panel will consist of representatives of voluntary health organizations—Dr. Reed Tuckson, who is the former DC Commissioner of Public Health, here today representing the March of Dimes, and Dr. Sanford Kuvin, who is representing the National Foundation for Infectious Diseases.

If both of you would please come forward, we look forward to your testimony. What we would like to do is permit each of you to summarize your testimony in whatever way you would like. We will include the entire testimony in the record, and if you could give us the main points that you think we need to focus attention on and any prescriptions that you have for how we might improve the situation, we would appreciate that too.

Dr. Tuckson, please go ahead.

TESTIMONY OF REED TUCKSON, M.D., SENIOR VICE PRESIDENT FOR PROGRAMS, MARCH OF DIMES, NEW YORK, NY[2]

Dr. TUCKSON. Thank you very much, Senator Bingaman. It is a pleasure for us to be here. The March of Dimes is very interested in this issue because we helped to develop the health objectives for the Year 2000 over the past year, and we think that these certainly do represent the broad and deep consensus of the American people.

We think it is vital that this Nation have reasonable and achievable health goals and objectives. We think that national goals for health will help us to define the minimum standard of health in this country. They will help us to prioritize our objectives and focus our attention and resources appropriately. They will also allow us to recognize and reward success, and even more importantly, will force us to hold ourselves as a Nation accountable for our failures.

We also believe that the goals will serve as the national symbol of our will and commitment to health, that they will encourage people to understand that it is a tragedy when we fall behind in vital areas like infant mortality, that it is vital for to us understand that the health of black babies is so much disproportionately poorer than the health of white babies. Once we know that information, once we are clear on it, I think then that we can rely on the strength and the ethics and the morality of the American people to want to care about that and give us the national consensus then to do even more to solve these problems.

Regarding the specific issues that reflect infant mortality, we completely agree on the objectives for infant mortality and the related parameters of neonatal mortality, postneonatal mortality, fetal death and maternal mortality. We think that those are very important. The first step in reaching these goals in infant mortality is, of course, public education, and we are pleased that this is recognized in the objectives. We fully support the draft objective of increasing to 90 percent the proportion of women aged 15 to 44 who know that alcohol, smoking and drug abuse pose risks to the fetus.

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[1] See p. 179.

[2] See p. 136 for Dr. Tuckson's prepared statement.

However, our suggestion, sir, would be that we would also want to have as a goal not only substance abuse, but other risk factors for poor pregnancy outcomes, such as that people would understand the relationship of sexually transmitted diseases—which are on an increase now in our Nation unfortunately—the relationship of poor nutrition and unintended pregnancy that they have on our issues.

We would also want to emphasize that professional education is important. We were happy to see that addressed in the Year 2000 goals, but we would hope that the definition of a primary care provider, the targets that are discussed, is understood to encompass nurse midwives, nutritionists, health educators, social workers as well as physicians.

In addition to education, pregnant women need access to basic prenatal care that results in good outcomes. We are strongly in favor of universal access to prenatal care for all pregnant women. However, given the current fiscal situation, as well as provider shortages in many areas, we believe that 90 percent may be the best that we can hope for, and that was what was indicated in the Year 2000 goals. We support increasing the proportion of women who get care in the first trimester to 90 percent as a reasonable and achievable goal, but again, we would hope that we would be able to have universal access eventually and ultimately. Hopefully we can at least reach 90 percent.

We are particularly supportive of the important objective of getting women into risk appropriate care that the document talks about. The March of Dimes is currently involved in a project with the American College of Obstetricians and Gynecologists in reexamining the issue of regionalization of perinatal care so that we do get people into the most appropriate therapeutic environments.

Genetic screening has long been an area of concern for the March of Dimes, and many of the screening tests discussed in the draft objectives were developed with the help of our funding and we fully support the utilization of these goals.

We are concerned, however, about the lack of specific objectives related to congenital anomalies. Birth defects are a major cause of infant mortality, and we hope that the final draft objectives will include specific targets for the reduction of birth defects.

The last area that I want to focus on is in the area of maternal substance abuse. You are aware, Senator, of the importance of this issue. Over the past years it has reached epidemic proportions. While we wholeheartedly support the objective of increasing by 40 percent the number of women who abstain from tobacco, alcohol, cocaine and marijuana use during pregnancy, we are concerned that more is needed. Specifically, an objective directed at increasing the proportion of pregnant women who are in treatment for drug abuse would be an ideal complement to the objective of increasing abstinence. If we recognize that we are not going to increase abstinence to 100 percent, then we need a treatment objective to go along with the abstinence objective. We are working around the country to try to do our part on this and we think that the national objective would certainly help to focus attention and track progress against maternal substance abuse.

In closing, sir, let me say that while the March of Dimes has offered some suggestions here, we unquestionably support the objectives and the process by which they were developed. We have every confidence in Dr. McGinnis and his staff at the Office of Disease Prevention and Health Promotion and we stand ready to assist them in any way that we can. These objectives are clearly consistent with the mission of the March of Dimes. We will use these objectives, and have already begun using them, as we start to develop the programming for the March of Dimes in our area of responsibility, and we see this as being therefore extremely important.

Senator BINGAMAN. Thank you very much.

Before I ask any questions of you, I would like Dr. Kuvin to go ahead and give his testimony.

TESTIMONY OF SANFORD F. KUVIN, M.D., VICE CHAIRMAN, NATIONAL FOUNDATION FOR INFECTIOUS DISEASES, WASHINGTON, DC [1]

Dr. KUVIN. Good morning. My name is Sanford Kuvin. I am Vice Chairman of the Board of Trustees of the National Foundation for Infectious Diseases in Washington, and I am also Clinical Associate Professor of Medicine at the Uniformed Services University in Bethesda, and at the University of Miami Medical School. I am Chairman of the International Board of the Sanford Kuvin Center for Infectious and Tropical Diseases at the Hebrew University Medical School in Jerusalem. And I would like to request that my written statement be made part of the record.

My purpose in being here today is to help this Committee in its deliberations about the Federal health benefits program and to inform you of a national tragedy incubating in the United States because of the failure to develop a national program to vaccinate targeted groups against hepatitis B.

Our Public Health Service objectives for the Year 2000 include a significant reduction in hepatitis B in all targeted groups, including 90 percent vaccination of all health care personnel. Are these objectives attainable? Certainly, yes, but they will most certainly not be reached with the current level of national apathy, ignorance at the public level, lack of professional education, lack of public programs and public funding, and in addition, the cost of the vaccine.

We must ask ourselves, isn't it true that hepatitis B is the most important chronic viremia in the world today, bar none, including AIDS? And isn't it also true that over 25 percent of chronic carriers of hepatitis B progress on to primary liver cancer, and therefore this vaccine which prevents hepatitis B in well over 90 percent of cases also prevents primary liver cancer and therefore is undoubtedly the world's first anti-cancer vaccine ever produced?

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[1] See p. 143 for Dr. Kuvin's prepared statement.

The United States is going through an epidemic of both AIDS and hepatitis B with hepatitis B almost unnoticed, with over 300,000 new infections reported in 1989 and with an estimated 1.5 million chronic carriers of the disease in the United States. There are almost 300 million chronic carriers worldwide. There have been 26 cases of HIV-AIDS reported in health care workers globally since 1982, but over 12,000 infections with hepatitis B in the United States in health care workers in 1989 alone, with over 250 deaths from the complications of either hepatitis B, primary liver cancer, or fatal cirrhosis.

This amounts to almost a needless death a day in unvaccinated American health care workers. This is also the first time in the history of the United States that the introduction of a safe and effective vaccine did not lower the incidence of disease, all because of apathy, ignorance, lack of professional education, lack of national programs and the cost of the vaccine.

The facts are that only 1 percent of the infections of hepatitis B are in health care workers, and this group has received 80 percent of the 2.5 million doses of the vaccine used in this country so far. Sadly, only 40 percent of all health care workers have been vaccinated, and shockingly, less than 24 percent of all physicians have received the vaccine. This means that the current strategies for hepatitis B vaccination are simply not working and that no programs have been initiated for the largest targeted groups affected, namely sexually active heterosexuals, who number about 22 percent of infections, IV drug abusers, who number 26 percent of cases, and homosexuals, who number about 5 percent; 30 percent of infections are in the unknown category of risk factors, but sexually active heterosexuals are the fastest growing group in this so-called unknown category.

The other major groups affected are the newborns of surface antigen positive pregnant women, Eskimos, prisoners, institutionalized mental patients, and Asian and African immigrant groups. About 30 million Americans need vaccination today. Several scattered actions have been implemented in the United States which are encouraging but fall far short of a significant step forward.

The "Ohio Plan" requires all dentists in the State to be immunized or show evidence of immunity to hepatitis B in order to be licensed. The "Yale Plan" requires vaccination of medical students in their clinical years, but this plan has spread to only 30 percent of the Nation's medical and osteopathic schools. Michigan is the first State in the Nation to recently pass a State law requiring prenatal screening of hepatitis B, and OSHA has recommended its first biomedical science regulation ever to protect all workers against hepatitis B and other blood borne pathogens.

Only recently Congress appropriated $10 million to be administered by the Centers for Disease Control for State public health use in controlling the perinatal transmission of hepatitis B. A systematized call to action to vaccinate all targeted groups in America can be carried out at the Federal, State and regulatory level, but only with the help of your Committee, Senator.

At the Federal level this includes legislation requiring free immunization for all health care workers, universal coverage by Medicaid and other Federal health insurance programs for all infants and adolescents, Immigration and Naturalization Service sponsored vaccination for all immigrants from high endemicity areas, vaccination for new military recruits, increased funding for sexually transmitted disease clinics, and increased funding for cost effective studies for the universal vaccination of all infants, all adolescents and other high risk groups.

Needed regulatory initiatives include encouraging the CDC and the Advisory Committee on Immunization Practices to implement the universal vaccination of infants and adolescents, implement OSHA requirements for workers at risk, including emergency personnel, and include hepatitis B in all AIDS education prevention program grants and contracts.

At the State level, legislation should require free vaccination for all State health care employees, place hepatitis B on the Medicaid formulary, require perinatal screening and newborn vaccination, and produce evidence of immunization or immunity for all health care students graduating from State schools, for health care students prior to clinical training and for all health care professionals in state funded institutions.

If we have no hepatitis B in the United States then we will not play "catch up" with the enormous prevalency rates in the rest of the world where primary liver cancer ranks amongst the most common of all cancers. There are national hepatitis B vaccination programs going on in over 22 countries in the world, but no national program in the United States.

The hepatitis B virus, like the AIDS virus, recognizes no international border, it doesn't need a passport and it doesn't need a visa. Hepatitis B is spread by exactly the same methods as AIDS—blood, sex, needles and birth—but unlike AIDS, the hepatitis virus is much more contagious. If you are pricked accidentally with AIDS contaminated blood your chances of getting AIDS are less than one half of 1 percent, but if you are pricked with hepatitis B contaminated blood, your chances of getting hepatitis B are almost 40 percent, but unlike AIDS, this is the first time we are in front of a virus in the United States and our medical intelligence is excellent. We are developing the weapons against AIDS, we have developed the weapon against hepatitis B.

Senator, in your opening statement you mentioned the need to concentrate on prevention and education. The great American public health physician Herman Biggs said in 1920, "Public health is purchasable. Within natural limitations any community can determine its own death rate."

I am no political scientist, but I am a medical scientist and a physician, and I believe that this coordinated call to action by the National Foundation for Infectious Diseases to fully utilize this safe and effective vaccine is the best prescription I know of to protect the health of the American people against this disease and to meet the objectives of the Public Health Service for the Year 2000.

Thank you.

Senator BINGAMAN. Thank you very much.

Let me first ask Dr. Tuckson a few questions if I could. One concern I have Doctor, is whether it is possible for us to popularize the effort to make progress toward the goals that are being identified. Dr. McGinnis laid out what has been designed, it is over 300 indicators in 26 different categories, an extremely thorough, comprehensive set of areas in which we need to make progress, but I am afraid that it is a little bit of inside baseball.

As far as the average person is concerned, they cannot relate to that. The average person does not have any real sense that progress is being made in areas that are understandable and relevant to his or her own life, and there is sort of a chasm, or a gap between the public policy and the responsibility of the individual citizen which I would love to see us find a way to bridge.

What we have talked about a little bit is some kind of an annual checkup which would provide information that could be widely disseminated to people. The information would include how the country is doing in some indicators that are relevant to the average individual and would have to be understandable.

Does that make sense, is that too big a gap to bridge, or are we talking about apples and oranges?

Dr. Tuckson. No, I am absolutely fascinated by your question. I think that you have put your finger on the major issue right now for the health community of this country. Somehow or another we have got to make the American people understand where we are in terms of the quality of the health of the American people. That quality of health, sir, is absolutely unacceptable, but there seems to be no consensus of thought by the American people that that is important, that it makes a difference in their own individual lives, that they make a difference, to therefore change their own individual behavior to give themselves the best chance to be healthy, but more importantly to me from my perspective is that we give then the impetus of individual citizens to care about the health of their fellow countrymen and women.

The way in which we use numbers is not as creative I think as it ought to be, and we probably don't do as good a job in communicating our message. When you give a list of 30,000 recommendations, or however many there are, 3,000, it does boggle the mind, and the average citizen gets confused in the midst of all of this data and it just becomes something to tune off when they watch television.

I think that you are right in your suggestion that we pick a few key things that we can explain well to the American people, explain why they are important, track and monitor those things, and maybe present them in a more creative way that causes people to care and calls for action. I think that you are in a unique position because maybe the health community—when it comes only from the health community maybe people just see the bias, well, that is just something that the health people care about.

If a United States Senator cared about it and said, look, as a representative of the American people I have gotten interested in these issues, and if you could help to help us communicate that, or give us advice how to communicate it, I think you will have done a great service. So I completely buy into the thesis of your question. Ultimately if we are unable to do what you are asking I don't think we are going to be successful in achieving these goals because there is not going to be the national focus, the national will on getting it done.

Senator Bingaman. If we could make understandable and properly focus in on some goals for the country that did relate to the individual, is it reasonable to think those could also be tied to a curriculum in the public schools? The schools would be working with the health care community and public health professionals to spread the word that these are the things that we as a country are trying to get fixed and this is how we are doing.

Three months ago we started a new decade, it would seem that there would be a different focus, or a different approach to health than we have had as a Nation before. We track the incidence of various diseases, as well as some other things, but we have never to my knowledge looked ahead and said, okay, where are we going to try to be in 10 years, and what actions need to be taken by individuals, and local state and Federal officials to get us there?

Dr. **Tuckson**. I see that as being very related, because there are only so many resources that we have as a Nation, and we occupy ourselves with a multiplicity of competing public policy demands. The role of education and the use of the school system is vital. Why do we educate our young people? I mean, what is the ultimate goal of that educational process? What is the ultimate goal that we come together in legislative or social bodies?

Ultimately it is for the survival of the group, the survival of the people. While there are many other wonderful utilities that should occur, if we don't live, if we don't survive, if our babies cannot survive the first year of life, why do we come together as groups? Why do we come together as a Congress? Why do we come together as a school system?

What is the information that we are educating our population about if ultimately it isn't about survival, whether we live or die?

And so do we use the school system as a way of implementing a preagreed upon set of priority information? Absolutely. Do we have a comprehensive K through 12 curriculum that encompasses in a logical, coherent fashion all the information that they need about something called cigarette smoking, about something called HIV disease, about something called sexual behavior, about something called how to eat properly so that you don't wind up with elevated levels of cholesterol and so forth and so on?

Do you put all of that into one comprehensive fabric so that the school system is not fashioned with the need to have a little piece of something over here and a little thing here and it is all done randomly and haphazardly and it doesn't utilize the limited resources most efficiently and intelligently?

Of course we have to do that, but before we can even get to that comprehensive, intelligent, well thought out K through 12 curriculum we have got to make the decision that in fact it is appropriate for the school system to care fundamentally about imparting the information that leads to the survival of the students as perhaps the first step, maybe more important than the other things that they are charged with doing.

Senator **Bingaman**. In your role as Commissioner of Public Health here in the District were you able to make any progress at getting attention to health education in the schools? Was that something that you had any jurisdiction or ability to impact, or was that just another group that had control over it?

Dr. **Tuckson**. First of all, I didn't have control over, but a good working relationship. But what I learned more than anything else as the Health Commissioner, Senator Bingaman, is the absolute frustration of caring about whether the citizens over which I had some degree of responsibility, the frustration of whether or not health was important in the total milieu of what occurs in the daily life of the issues that confront a city.

The school system is so bombarded with so many other competing issues that trying to get a health curriculum introduced and implemented didn't fare very well against other sorts of things, other confusions, other competing demands. I found that in every part of dealing with our government, when we make decisions about the allocation of very precious rescurces, other things always seem to be more important than whether or not people live or die. It is a paradox that I have never fully understood when you say to people the rates and statistics of death and disease.

For example, if we say in a city like the District of Columbia that 900 people died last year from cigarette related illness, you would think that that would cause a tremendous outpouring of energy, of commitment on the part of all parts of society, particularly of the school system, to really, really focus on let's do something about not smoking cigarettes because to have 900 people in one small city like this die from that one cause a year is an extraordinary thing.

What do the newspapers focus on in this city? The violence rate, how many people died from homicide. Well, yes, that is a terrible statistic that 300 and some people die every year. But even though we talked about it, at no time did the newspapers ever report in any significant degree of attention the 900 people that died from cigarettes. It is a very frustrating thing to try to get hold of.

Ultimately, the answer specifically, in brief, to your question, sir, is that the superintendent of schools is interested now in implementing a K through 12 comprehensive curriculum. I hope that he will be able to do that. The problem that he is going to have though is that his agenda is crowded with so many other things that other interest groups want, I don't think he is going to have the resources. I don't think those teachers are going to care individually about it enough to make it a priority. I am very pessimistic whether he will get this accomplished.

Senator **Bingaman**. All right. Thank you very much.

I would like to ask Dr. Kuvin a few questions. Doctor, you sound a very alarming set of circumstances here which face the country. Those of us who are not in the medical profession, the lay people in Government, are trying to figure this all out. I have assumed that the Centers for Disease Control had sorted out what our major health risks were as a Nation and was working away to fix them. Then you come to me and say, here is something that is killing more people than AIDS and we have no program on it, other than $10 million that the Congress appropriated.

But why isn't this on the top of the Centers for Disease Control's list, or at least very near the top of the list of things it is addressing?

Dr. **Kuvin**. Firstly, the Centers for Disease Control has been an excellent source of medical intelligence for this Nation. The Centers for Disease Control is yet another Federal agency which has to be supported from the Congress by the budget that comes out of these halls. The CDC has petitioned the Congress for monies for hepatitis B unsuccessfully.

Senator **Bingaman**. That was in this year's budget request from the administration?

Dr. **Kuvin**. Yes, sir, and this was the first time that monies have been allocated to any public program ever, the $10 million that was authorized for State use for perinatal hepatitis B programs. In fact, the National Foundation for Infectious Diseases—and I am Chairman of the Subcommittee on the National Coalition on Hepatitis B Immunization—is having a conference in May in Orlando where experts from around the country, in association with the CDC, are meeting to advise the CDC how to spend this initial $10 million. But this is only a beginning, if indeed the monies are forthcoming.

Senator **Bingaman**. Let me see if I can be clear on what has happened. Is it in the current years budget?

Dr. **Kuvin**. Yes, sir.

Senator **Bingaman**. There has been $10 million appropriated?

Dr. **Kuvin**. Yes, sir.

Senator **Bingaman**. Or there has just been $10 million requested?

Dr. **Kuvin**. No, $10 million appropriated.

Senator **Bingaman**. Appropriated. So there is a $10 million amount sitting there waiting to be used?

Dr. **Kuvin**. That is correct. The other point is that the CDC has submitted significant programs to the GAO and other agencies indicating what would be best for the United States in terms of is it possible to eradicate hepatitis B from the United States? The answer is unequivocally yes.

But the correct public health approach is to vaccinate all infants, all adolescents and all targeted groups. There have been numbers that have been put forward as to how much this would cost.

Senator **Bingaman**. What are those numbers?

Dr. **Kuvin**. The numbers basically are that for vaccine, with personnel and education, for infants alone it would cost about $50 million a year through the Year 2000. For adolescents you would have to add another $100 million on to that, making a total budget of about $150 million through the Year 2000, and then falling to a maintenance level of about $30 million per year. For all infants, all adolescents, and all targeted groups it would go up to about $210 million by the Year 2000, a year, and then fall to a maintenance level of about $30 million a year.

I would also like to indicate that in 1978 the direct costs to the United States for hepatitis B, when the incidence of new infections was far less than it is now, was $350 million a year. In 1988 it was over a billion dollars a year.

Senator **Bingaman**. Tell me again, that billion dollars a year was for what?

Dr. **Kuvin**. For direct costs. Never mind the indirect costs of pain and suffering, loss of jobs, whatever, but just direct costs, over a billion dollars. It strikes me that universal vaccination is a very modest price to pay for prevention in terms of cost savings to our Government. First of all, cost estimates have been done in the past as to cost effectiveness of the hepatitis B vaccine. In the mid 1980s a study was done at Duke University indicating that it would take

7 years to invest in costs before savings were produced on a significant scale. And that 7 year rule I think you can count upon to be a reliable broad brushed estimate as to what it will cost versus the savings down the road.

Senator **BINGAMAN**. Let me just be clear then that the $210 million figure is to do the whole thing on an annual basis, and that is a figure that the Centers for Disease Control came up with?

Dr. **KUVIN**. Yes, sir.

Senator **BINGAMAN**. And that is their estimate from now through the year 2000?

Dr. **KUVIN**. Yes, sir. It would begin at lower levels, of course, and it would work up to the $210 million. It would begin at $30 million or $40 million a year. Within 3 years it would probably work up to the $210 million level. These are gross estimates, of course, but the CDC has done a great deal of work in searching out these efforts.

Senator **BINGAMAN**. You cite several things that ought to happen that, are not particularly expensive, and it seems as though none of them have been done either. My question is, if the Centers for Disease Control is in agreement with you on the importance of this, why don't they do some of the things which don't cost any money?

You suggest, for example, that they include hepatitis B in all AIDS education prevention programs. Now, why can't that be done for minimal costs?

Dr. **KUVIN**. Well, I am not an expert on AIDS, Senator. However, it is my understanding that AIDS education programs don't only come under the CDC. They come under a number of Federal agencies and nonfederal agencies. The investment of this country of $2 billion in AIDS has been extraordinary, but when we compare that with minimal public monies of $10 million for hepatitis B vaccination, that is shocking.

Senator **BINGAMAN**. I guess what I am trying to penetrate a little bit here is does it require Congress to come along and pass a law every time a new disease requires attention by our public health system? Is our public system incapable of prioritizing and responding to the changing demands that we encounter? We could, and may well, put together legislation to require all of the things that you are talking about here and try to get appropriators to agree with us that it is important enough to put some money into, but why should Congress have to legislate this kind of stuff?

Dr. **KUVIN**. Basically because our medical system is in disarray, and basically because there is a failing and a falling standard of medical practice in the United States.

Senator **BINGAMAN**. As a public health issue, where is the Secretary of Health? Why isn't he testifying to the Congress like you are?

Dr. **KUVIN**. The Secretary of Health just did—not testify—but the National Foundation for Infectious Diseases hosted a national forum on hepatitis B and AIDS in November in Washington, and Dr. Sullivan and Dr. Mason were both on the program and spoke loudly and clearly about hepatitis B and its threat to the American public.

Senator **Bingaman**. Do you know what they requested Congress to provide in the way of funds in the 1991 budget that they sent to the Hill?

Dr. **Kuvin**. No, sir, I do not.

Senator **Bingaman**. Okay. Well I think your testimony is most useful and has certainly caught my attention. We will try to explore this more and see if there is something we can do through this Subcommittee to get attention to this problem. It is one that I, very frankly, was not aware of in the magnitudes that you describe.

Dr. **Kuvin**. When 22 nations around the world have national programs for hepatitis B and we have nothing, that is absolutely shameful, it is a national tragedy in incubation.

Senator **Bingaman**. In the goals for the Year 2000, is there a reference or a specific indicator with regard to hepatitis B?

Dr. **Kuvin**. Absolutely, sir. There are clear indicators as to what the levels of prevalency are, new infections now, and what they should be by the Year 2000. For example, one recommendation was 90 percent vaccination of all health care personnel. That simply will not happen under current circumstances.

Senator **Bingaman**. All right. Well, this has been most useful. I appreciate the testimony of both of you very much.

Dr. **Tuckson**. Thank you very much, Senator.

Senator **Bingaman**. Thank you.

Our second panel consists of Stanley Karson, the Director of the Center for Corporate Public Involvement of the life and health insurance industry, and Dr. Robert S. Lawrence, who is Director of the Division of Primary Care at Harvard Medical School.

Mr. Karson, why don't you go first. We appreciate both of you being here.

TESTIMONY OF STANLEY G. KARSON, DIRECTOR, CENTER FOR CORPORATE PUBLIC INVOLVEMENT, WASHINGTON, DC [1]

Mr. **Karson**. Thank you, Mr. Chairman. I am Director of the Center for Corporate Public Involvement, an 18-year program of two insurance trade associations, the Health Insurance Association of America, and the American Council of Life Insurance. The Center works with and for almost 700 health and life insurance companies across the country on their community and social projects, with a particular emphasis on health and wellness, AIDS, education, the elderly, the hard-to-employ, housing, and hunger and the homeless.

In 1977, the industry body of CEOs that directs the Center's operations, the Committee for Corporate Public Involvement, agreed that health education and promotion should be a priority concern of this industry. In order to provide the most professional and expert guidance to the industry in this then emerging field in the late 1970s, we established the Advisory Council on Education for Health, a group of outstanding men and women widely respected in this health area. A list of its membership from that time to the present is attached to my prepared statement.

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[1] See p. 151 for Mr. Karson's prepared statement.

Out of the first meetings of this group came a consensus that if the industry wanted to make notable contributions to the cause of disease prevention, leadership was indicated in 2 areas—smoking cessation and the role of the primary care physician in health risk reduction.

Now in 1990, when anti-smoking campaigns have become the norm in the Nation, our industry's part in alerting first our employees and then our corporate and individual policyholders to the perils of tobacco may not be fully appreciated. Time does not permit me to cite the details of our early record of the anti-smoking campaign in this country, but I think you would be interested in two figures from the 1989 Social Report of the Center for Corporate Public Involvement: 84 percent of the reporting life and health insurance companies had non-smoking restrictions in effect at their home offices, and 36 percent had instituted a total ban on smoking in their buildings.

The other health promotion priority, Mr. Chairman, is one that the Advisory Council recommended to the industry because of the feeling that the role of the primary care physician was essential in advancing the cause of health promotion through providing preventive care services, including counseling, and periodic examinations for the patients that the primary care physician served. Thus born the Lifecycle Preventive Health Services Study, undertaken by INSURE, an industry-sponsored non-profit organization. It took 7 to 8 years and was completed 2 years ago, and funded by 88 insurance companies, the Robert Wood Johnson Foundation, the Kaiser Family Foundation, the MacArthur Foundation, and later by the U.S. Department of Health and Human Services.

We found out at the end of the INSURE study that the doctors involved, given the proper information and publications, were delighted to provide these preventive care services, including 15 extra minutes of time for the physician to counsel the patient on the risk factors discovered in the examination of the patient. The patients were even happier to get this kind of input. Indeed, in the longitudinal part of the project we found that the patients did change their lifestyle behaviors enough to have a positive effect on a number of their health risks.

I would ask that the results of the INSURE study recently published in the American Journal of Preventive Medicine might be included in the record of the hearings.[1]

Senator BINGAMAN. We will be glad to include it.

Mr. KARSON. Now, as an industry it is too soon to tell whether insurance companies will eventually implement the findings of the Project, whether they will fashion products to cover preventive care and market them aggressively. Currently, although some companies can point to trials or pilots or options for policyholders who want such coverage, companies have been admittedly slow in introducing new policies using the INSURE Project guidelines.

The stated reason is that the current costs of health insurance serve to tip the scales in the other direction: to reduce costs to group policyholders rather than add new benefits. The competitive factor in group insurance does not encourage add-ons in policies these days—unless, of course, the customer demands it, or companies can find ways of offering preventive care benefits without increasing costs, for example, by providing it as one option among other benefits, or by having the employee absorb all or most of the cost. And for those of us who believe that reducing risk factors through preventive care reduces claims, costs may well be reduced too.

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[1] See p. 290.

As for health promotion as a larger issue, our industry still maintains its commitment. Many insurance companies have developed and supported innovative health promotion programs for employees, policyholders and the general public. The industry's annual Social Report shows that employee programs such as fitness facilities, AIDS education and hypertension screening are widely available, and one company, Metropolitan Life, has been a national model for support of health promotion throughout this century, first with visiting nurse programs, and more recently through assisting comprehensive health education in the Nation's public schools, a critical need that you addressed earlier this morning, Mr. Chairman.

It has become all too clear to those of us working in this field that low income and minority populations are at the highest health risk while being the most underserved in health promotion information. For this reason, and also because many in those groups are in the ranks of the uninsured, the two trade associations I mentioned, the life and health insurance associations' boards, have approved a new health promotion priority for the industry: the health risks of low income/minority Americans. A Subcommittee of our Advisory Council, chaired by Dr. Robert Murray, Jr., of Howard University School of Medicine here in Washington, will be deliberating this spring to recommend approaches and activities to our member companies to address this critical population.

Finally, our industry has had a major role in creating the concept and the existence of wellness councils in many areas of the countries. The purpose of these wellness councils is to encourage and coordinate the health promotion programs of employers, private and public, in a given area. We are aware of and grateful for the critical support you, Mr. Chairman, have provided in setting up a similar group of employers and others concerned with worksite health education programs in your State of New Mexico.

While the health and life insurance industry is proud of its early and consistent leadership in health education and promotion, we fully realize the improvement of the health of the American people is an enormous and continuing challenge. It is beyond the means of any one segment of society, public or private. That is why we have worked with the U.S. Department of Health and Human Services in the development of the Year 2000 Health Objectives for the Nation. They must be better known, understood, and implemented if our mutual goals of better health and quality of life for all Americans are to be attained. The health and life insurance industry stands ready to continue to work for these objectives.

Thank you, Mr. Chairman.

Senator BINGAMAN. Thank you very much.

Dr. Lawrence, why don't you go ahead with your testimony before I ask any questions.

TESTIMONY OF ROBERT S. LAWRENCE, M.D., DIRECTOR, DIVISION OF PRIMARY CARE, HARVARD MEDICAL SCHOOL, CAMBRIDGE, MA [1]

Dr. LAWRENCE. Good morning, Mr. Chairman. I am pleased to be here today to discuss the Year 2000 Objectives for the Nation. I am Director of the Division of Primary Care at Harvard Medical School, and Chief of Medicine at Cambridge Hospital. From 1984 to 1989 I had the privilege of chairing the U.S. Preventive Services Task Force, a group which developed clinical preventive services recommendations for the Office of Disease Prevention and Health Promotion of the Public Health Service.

You have asked me to comment on whether the Year 2000 Objectives are reasonable, measurable and attainable; whether they target specific populations realistically; and what areas of research should be pursued in order to reach those objectives; and whether the problems of community health promotion are realistically addressed in the plan. The best current measure of the appropriateness and feasibility of the Year 2000 Objectives lies within an examination of the utility of the 1990 Objectives. The publication of Healthy People in 1979 represented the first comprehensive Federal report on health promotion and disease prevention. It recognized the new morbidity of a large and growing burden of preventable or postponable death and disease caused by unhealthy personal behaviors, environmental hazards and barriers to access to health care. It set the stage for developing the 1990 Objectives by identifying the major areas where the health of the Nation needed improvement.

Fifteen priority areas within three major categories were identified: Preventive services for individuals such as high blood pressure control, family planning, pregnancy and infant health, sexually transmitted diseases; health protection for population groups, such as toxic agent and radiation control, occupational safety and health, accident prevention and injury control, fluoridation and dental health, surveillance and control of infectious diseases; and finally, health promotion for population groups, such as smoking and health, misuse of alcohol and drugs, nutrition, physical fitness and exercise, and the control of stress and violent behavior.

The process for developing these objectives 10 years ago was very much top-down. Various Government agencies, such as NIH and the CDC, developed background papers for a conference of health experts. The experts in turn used a consensus process to develop the objectives which were then sent out to more than 2,000 groups for review and comment. The final publication, Promoting Health/Preventing Disease: Objectives for the Nation, contained 226 specific objectives in these priority areas.

These objectives were quite heterogeneous. Some were statements of ideal health conditions, and as such might serve to challenge the Nation's health leadership but were hardly useful for managing-by-objective. Other objectives were feasible if appropriate strategies could be developed and the necessary resources made available. The remaining objectives could be regarded as probable outcomes, even if no changes occurred in the way health promotion and disease prevention services were delivered. Like the ideal objectives in the first group, the probable objectives lacked managerial or planning power and tended to obscure the basic importance of the feasible objectives. Clearly, the lesson to be learned here as we prepare the final draft of the Year 2000 Objectives is that they should focus on feasible outcomes while placing little or no emphasis on unrealistic, ideal objectives, or the probable or secular trend objectives that will occur regardless of what the community response is.

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[1] See p. 161 for Dr. Lawrence's prepared statement.

The mid-course review of 1985 produced mixed results. Encouraging results were seen in the priority areas of hypertension control, immunizations with the exception of hepatitis B, control of sexually transmitted diseases, with the notable exception of AIDS, toxic agent and radiation control, accident prevention, and infectious disease control, smoking cessation, and control of stress and violent behavior. The results, however, for family planning, maternal and child health, occupational safety and health, nutrition, and physical fitness and exercise were very disappointing. Several of these latter priority areas reflect ideologic disagreements and the lack of a national consensus on such critical issues as sex education, the availability of contraceptives, the right rather than the privilege of access to prenatal care, and the appropriateness of strict standards for protecting the health of workers.

The 1990 Objectives have served a useful purpose in bringing into sharper focus the need to debate and resolve these ideologic differences in the interests of the health of the American people. The discrepancy between the health status of minority groups compared with the majority population remains unacceptably large. The infant mortality rates, both national and for our minority groups in particular, continue to be a disgrace. At the same time we continue to spend a greater proportion of our GNP on health care than any other industrialized society, while the numbers of our citizens who are uninsured or underinsured continue to grow.

The process of developing the Year 2000 Objectives has clearly benefited from experience with these earlier objectives. The new ones are equally comprehensive while reflecting the broader participation in their development, relying more on a bottom-up approach. As you heard from Assistant Secretary Mason on March 20th, there was greater involvement of local Government and private agencies through the hearings conducted in different regions of the country by the Institute of Medicine and the U.S. Public Health Service. More than 2,000 individuals have contributed commentary or review on 21 priority areas containing over 300 objectives in the draft report. Important omissions have been corrected with the inclusion of sections on Human Immunodeficiency Virus infection, cancer and functional status of the elderly. A fourth priority area, Systems Improvement, was added to emphasize the importance of addressing the problems of the delivery system in order to achieve the objectives in preventive services, health protection for population groups, and health promotion for population groups.

The criteria are more explicit and therefore they should be more accurately measured. Unfortunately, some variations persists in the statistical methods used and in the expression of data. Every effort should be made in editing the final version to eliminate those objectives where baseline values or target values are either not available or not stated. Similarly, those objectives that are unmeasurable should be deleted to enhance the effectiveness of the document as a management-by-objectives instrument, to use your words, a national report card that reports on things that really can be managed. It is critically important to have a consistent, reproducible approach to data collection and interpretation to assure credibility, clarity of communication, and the setting of standards. We learned in the work of the U.S. Preventive Services Task Force that the adoption of a common methodology to assess the quality of evidence regarding the efficacy and effectiveness of a given preventive service was essential to the formulation of coherent policies.

The quality of the information on health promotion depends on close attention to the following statistical challenges: the inclusion of baseline data for all objectives; avoidance of vague or unmeasurable objectives; precise identification of target groups; internal consistency for data presentation; uniform definition of measurement parameters—in other words, rates expressed as per 100,000 population throughout the report rather than per 10,000 here and per 100,000 there, or, in fact, crude numbers rather than rates at all have sometimes crept in; the use of absolute targets expressed as rates; the choice of target values that are based on trend analysis—and by this I mean rather than just predicting a favorable outcome 10 years in the future, some of the objectives are probably not going to exceed what would have happened just with the secular trend without any real management by the health community, so we should raise our standards and establish target values that exceed the current secular trend; and finally, adoption of standard methods for national, state and local data collection.

The 1990 Objectives were not given a priority ranking. This is understandable given that the process was new and that the effort expended was enormous. The Year 2000 Objectives, however, should be ranked by priority to improve their effectiveness as a management tool. The health status and risk reduction objectives deserve highest priority. The public awareness, professional education and awareness, and service objectives are important for achieving the national health status objectives but are not, properly speaking, objectives themselves. Rather, they are enabling factors critical to achieving the overall objectives.

The objectives must be linked to existing data sources to assure the availability and reliability of data to monitor progress. The National Health Interview Survey is the single most important component of the national surveillance system required for the accurate assessment of progress toward the objectives. The Behavioral Risk Factor Survey performed at the State level is next in importance. Unless the proposed level of funding for the National Center for Health Statistics is altered to provide appropriate inflation adjustments, I have serious doubts that the National Health Interview Survey will continue in its current form. Without it, the entire planning and management value of the Year 2000 Objectives will be severely compromised. We have learned too much from the 1990 Objectives and the burden of premature disease, disability and death is too great among the American people for us to take that chance. Only through maintenance and improvement of current data systems will we be able to evaluate the effectiveness of health promotion interventions and judge the efficacy of research interventions.

Thank you for this opportunity. I will be pleased to respond to any questions.

Senator BINGAMAN. Thank you very much. Let me ask a few questions of each of you.

Mr. Karson, it seems to me, given the way health care is provided and paid for in our society, that the private providers of insurance, both health and life, but health insurance more specifically could have a very dramatic impact on attention to some of the things which are dealt with in the Year 2000 goals. Maybe this is happening. I would like for you to tell me the extent to which it is.

For example, wellness programs that various corporations are engaged in I think have been a very good thing and have improved the general health of employees of those corporations. Johnson & Johnson I think is an example. There are many, many examples nationwide I think of success. I don't know the extent to which any insurance company provides health insurance at a discount to people who participate in wellness programs, or provides a financial incentive for companies to implement wellness programs and involve their employees in them.

Is that happening?

Mr. KARSON. Yes, Mr. Chairman, it is happening. It is not happening as much as you and I might like it to happen, and there is a reason, of course, which has to do with the insurance mechanism. Many people do not realize, as I think you do, that the vast majority of health insurance coverage is group insurance in this country today, 85 to 90 percent. Of that amount, the majority is self-insured plans. In other words, the corporations themselves are mainly paying the claims of their employees. They are not buying insurance to do that. They do contract with insurance companies to administer these self-insured plans.

So I am saying with that kind of a structure and system it is not a matter of the insurance companies going out and saying we want you to buy a plan which will provide an incentive for wellness programs. Insurance companies have these, many of them, already. The employer, the group insurance policyholder, must want these plans and must pay for the cost of that kind of a coverage, of course.

I don't want to cite specific insurance companies for commercial purposes here, but there are several now that are providing discounts to group policyholders—that is, the employer—for those employees that do undertake various kinds of health promotion programs, fitness, weight loss, watching hypertension, cholesterol and the rest. They are in existence.

But, again, it is a matter of the corporation in this country, the policyholder for most of American workers in terms of health insurance, to request this kind of coverage. It is there, the insurance company would be delighted to provide it at the cost that is required.

Senator BINGAMAN. Let me get down to a specific. Just before the hearing you and I were discussing a program that I have worked on out in New Mexico called "Health Net New Mexico" where we ask employers to participate and then make it available to their employees. It is a minimal health education campaign which goes on each year for about a 10-week period. That is what the program has been.

Here is the dilemma that we find ourselves in. When you go to Johnson & Johnson and say is this valuable to you, they say no, we are already doing it. And they are. They have a much better program than we are able to provide. And when you go to small employers with 100 or 50 or fewer employees, and say why don't you get active and support this and encourage your employees to involve themselves? They say, show me how it will improve my bottom line; I mean, I am not opposed to health, but I am not willing to pay for it unless there is some way that this benefits me in the insurance I have to pay for these employees, or something to that effect.

Are you telling me that there are insurance companies that would in fact provide a better rate on insurance for companies that participated in a program like that if it was properly explained to them? Is that what I understood you to say?

Mr. KARSON. Yes, that is the case, Mr. Chairman. I am not saying that every company has these, but there are companies that are evolving these kinds of incentive and discount programs.

Senator BINGAMAN. Well, I appreciate hearing that, because that is news to me. And we may follow-up with you after the hearing to get more information on how that is developing with specific companies.

Let me ask a similar question, which may have a similar answer to it. Dr. Tuckson was talking about cigarette smoking. How many companies are there that provide a discount for health insurance for people who don't smoke?

Mr. KARSON. A large number, I am pleased to be able to say. And the reason that there is a large number for that particular risk factor is because that is the one that we have been able to evaluate and follow on a long-term basis, 15, 20 years in some cases. There are well over 100 insurance companies that provide discounts for policyholders who don't smoke, have given up smoking and so forth.

Senator BINGAMAN. On the subject of Federal Government health benefit plans. My understanding is that until recently those plans did not offer coverage for physical checkups, that was not part of what you were able to get as part of the plan. And now just a few of them offer such coverage.

Is that your same understanding, or have you looked into that? Also, what about in health plans in the private sector? Are checkups by people on a periodic basis such as every 3 years or so something that is covered in health insurance on a regularized basis?

Mr. KARSON. Not typically, Mr. Chairman. There are some exceptions where employers request it, pay for that kind of coverage, but typically annual physicals or periodic physicals are not covered under health insurance. They are not considered to be an insurable event, meaning it is not something which is unpredicted, which is what the basis of insurance is. And certainly insurance companies, as concerned corporate citizens about health promotion, would advocate that people do take these annual examinations, periodic examinations. But they are not covered under health insurance for the most part.

Senator **Bingaman**. Do you think we should move toward more coverage of those kinds of things where it is essentially a totally preventive activity.

Mr. **Karson**. Well, again, Mr. Chairman, as a person who is concerned about health promotion I would encourage all Americans to look at the importance of undertaking these examinations. As someone within the insurance industry, I have to point out that if you include these kind of examinations for all policyholders—which means most Americans—it would increase the cost of health insurance, for the employer for the most part, to a great extent. Many employers now provide periodic examination for their employees as an employee benefit, not a health insurance coverage, so they are now paid for by many employers in any case.

Senator **Bingaman**. Dr. Lawrence, let me ask you a few questions. If we do not have the National Health Interview Survey, it is your testimony that we really are eliminating a lot of our capability to measure the progress we make toward the Year 2000 Objectives. Is that what I understood you to say?

Dr. **Lawrence**. Yes, Senator Bingaman. I would say—again, using your concept of a national report card—it would be a little bit like telling the school children that there aren't going to be any final exams this year and so we are really not going to know whether you met the learning objectives for this particular curriculum. I believe that the value of the National Health Survey has really only in recent years begun to be fully appreciated. It has been around for now 14 or 15 years, but the nature of the questions that are asked repeatedly of a statistically significant sample of the population really have allowed us to track the shifts in smoking behavior, the shifts in sexual practices, the shifts in hypertension control and so on, and without that the ability to really constantly refine the priorities, to reestablish new objectives, and to actually manage the process of providing health promotion services will be flawed.

Senator **Bingaman**. Your suggestion in your testimony was that we drop some of those objectives that are not clearly measurable now. Is there a benefit of maintaining objectives that we cannot today measure with the idea that in the future we may be able to measure them and therefore we want to keep them on our list even though we are not going to be able to tell with any precision how well we are doing in getting there?

Dr. **Lawrence**. If there are efficient ways of collecting baseline data that will approximate some future measurement parameter, I think that would be a reasonable choice. But I would rather see the attention of the American people focused on those things about which we have harder data. If I can mix my answer with a response to your earlier question to Mr. Karson, Southern California Edison has 18,000 employees. About half of them are covered within a company-provided health benefit self-insurance program. The other half participate in an IPA program with clinicians and other health deliverers in Southern California. Several years ago they focused on what should be among the highest priorities for the health objectives, five modifiable risk factors—smoking, hypertension, obesity, lack of exercise, and diabetes.

They said to their employees, we will give you $120 back on your co-pay if you will come in and be checked for these five modifiable risk factors. If you are within the target areas, we will give you that $120, but so as to avoid any ethical dilemma of blaming the victim, they also said, and if you happen to fall outside of the target areas for any or all of those five risk modifiable risk factors but are willing to make a good faith effort to work on one of them we will also give you $120 back. In the two years since they have implemented that program they have noticed a decline in the use of emergency services, a decline in sick days, a decline in other expenditures from their health benefit program, and this year their $100 million self-insurance program came in $11 million under budget.

The problem with this example is that it was not a randomized clinical trial, it did not attempt to do what the INSURE project did of really trying to control for the sources of bias that might have also been going on. There may have been over secular trends influencing the health behavior of the Southern California Edison people. But it does illustrate a great promise for using a very focused, limited number of objectives where you know the yield is likely to be high. If you cloud the objectives, either through imprecision of measurement parameters or lack of data of efficacy of the intervention, then I think it just ends of blunting the effort.

Senator **BINGAMAN**. Okay.

Mr. **KARSON**. Could I just add to the doctor's response that I am in total agreement with that from the standpoint also of the usefulness of hard data, which we really do not have in many of these programs. If we did have them, it would be better for my industry, the insurance industry, in being able to reach a better premium basis for discounts and that kind of thing, it would be better for the employers who want to undertake these programs to be able to see that there are cost savings, and we believe there are, but there is not much hard data that supports some of this. So we would certainly agree with Dr. Lawrence's response.

Senator **BINGAMAN**. Okay. Dr. Lawrence, I am intrigued by your suggestion here that the Year 2000 Objectives should be ranked by priority. It would be great from the point of view of Congress, and I guess the administration, to be able to look at these 330 some odd indicator areas and have someone tell us if you have a billion dollars to spend improving the health of Americans, here is where to put it to have the biggest bang for the buck.

Are you suggesting that that kind of recommendation is possible and that Congress could hope to have something resembling a consensus from the public health community which said if you have only X number of dollars to spend, here is where you should spend it and here is the way to allocate? Is that a real conceivable possibility?

Dr. **Lawrence**. I think we are able to make a very large start on that. There is still a lot of imprecision about some of the measurement parameters that we have. The work of the U.S. Preventive Services Task Force that led to our publication last November of the Guide to Clinical Preventive Services attempted to do just that. We used three ways of establishing priorities. First and foremost was the quality of the evidence supporting the effectiveness of the intervention. Mammography for women over the age of 50 works, randomized clinical trial data show a 27 percent reduction in mortality rates. Screening for colorectal cancer, unfortunately we still don't really know about. It is one of our agnostic recommendations. And we have taken a lot of criticism from the National Cancer Institute for our reluctance to say to all Americans that you should have annual sigmoidoscope exams over the age of 40.

But I think what we did by emphasizing the quality of the evidence on the effectiveness of the prevention intervention, and then factoring in the burden of suffering, so if there is a huge problem out there like low birth weight and infant mortality rates, even if the quality of evidence is not absolutely certain, the magnitude of the problem deserves having that move up on the priorities. And then finally, we evaluated the characteristics of the intervention itself, its cost, its acceptability to the American public and to the health professions, and its operating characteristics, the sensitivity and specificity of the test or the effectiveness of the counseling or intervention.

I believe that we could take these 330 objectives and apply a similar methodology to begin to say here are the 10 or the 20 or the 30 where the evidence is excellent, where the burden of suffering is very large, and where we know enough about the kind of intervention to do whatever is necessary to put it into effect if the resources are there.

Senator **Bingaman**. Let me just take a specific. Dr. Kuvin testified that hepatitis B is a major national problem that is going unaddressed and that vaccination of up to 30 million Americans should take place today for hepatitis B. The obvious question which Congress and the administration are faced with, is whether that is the best use of the limited resources we have in health care or in public health. If we were to take the recommendation that he gave and propose $210 million a year be spent dealing with this problem, obviously there are a lot of people who are going to say that hepatitis B is not the highest priority use for this money.

How does that rate? Could your group that you just alluded to give us a recommendation and say, based on our assessment of things, hepatitis B is either something that is high on the list or low on the list?

Dr. **Lawrence**. Well, among the 60 risk factors or conditions and the 169 prevention interventions that we reported on in our findings, hepatitis B vaccine was clearly in that group.

Senator **Bingaman**. It was in the 60?

Dr. **Lawrence**. It is in the 60. If we were to take, however, the 30 million Americans who are potentially at risk, at the current cost of vaccine, which is still about $100 per dose, you are talking about a $3 billion expenditure. So then that third category of the acceptability, the cost, and the sensitivity and specificity of the intervention begins to be very important. When we applied that parameter, what we came up with as a recommendation was that the people at high risk for hepatitis B infection should be immunized first. Those include health workers who are exposed to blood splashes and needle sticks. It includes intravenous drug abusers and gay males. It includes people who are also promiscuous sexually.

Now these are the high risk groups for HIV transmission as well. The reason that we would hesitate to say that Congress should appropriate sufficient funds to immunize 30 million Americans is that we have learned a lot from the successful smallpox immunization campaign and the elimination of smallpox, and that was the containment strategy that Doctors Henderson and Foege developed. If you identify first those who are at the greatest risk of being infected and then transmitting the disease and essentially create a cordon sanitaire around the rest of the population, you can achieve very, very good effect with a much lower penetration of the at risk group.

But I think that in order to have that kind of strategic planning and that kind of national effort, I would agree completely that it is a disgrace that we do not have a hepatitis B vaccine policy in the United States today.

Senator BINGAMAN. Going back to your earlier statement that you really could go in and prioritize those areas where we can make the most cost effective investment to improve the health of Americans, how does the Congress go about getting that? If I wanted to ask you, or somebody, to tell me what 10 things we ought to do in the Year 2000 Objectives, what are the 10 most important things that are recommended that the Congress should do to help deal with the problems, how do I get someone to give me that list?

Dr. LAWRENCE. Well, I would say that the first two things would be to be sure that there is adequate budget support for the National Health Interview Survey, and the second thing would be I would see that the Office of Disease Prevention and Health Promotion received adequate funds to support the kind of priority setting process that might take a year or 2 to complete.

Senator BINGAMAN. So we should essentially direct the Office of Disease Prevention and Health Promotion to do that and give them the funds to do it?

Dr. LAWRENCE. That's correct.

Senator BINGAMAN. How much does that kind of an effort cost?

Dr. LAWRENCE. Well, it depends on how you involve the rest of the health community. The 20 of us who served on the U.S. Preventive Services Task Force were nonfederal employees. We served pro bono. We had 14 meetings over 4 years with countless hours of work between meetings.

I think you can tap into the good will and the concern of the public health and the clinical community in the United States to lend a hand. What would be needed would be a relatively modest amount of core support for staff in ODPHP, perhaps for contracting with groups like the Institute of Medicine and other bodies of experts that could provide assistance, just as they have with developing the objectives, themselves.

Senator **Bingaman**. Do you think 12 months is a reasonable time in which to ask for that report back?

Dr. **Lawrence**. I think it would be pressing them a bit. It is a complicated process, but I think that you could get certainly a first cut within 12 months that would allow then targeting some of the most obvious high priority issues. But further down the list it is going to take a little more data analysis and data collection.

Senator **Bingaman**. All right. This has been very useful. I appreciate the testimony of both of you.

We have an additional witness, Dr. Earl Fox, who is the State Health Officer from the Alabama Department of Public Health in Montgomery. Dr. Fox is representing the Association of State and Territorial Health Officials.

Thank you for coming, Dr. Fox.

TESTIMONY OF CLAUDE EARL FOX, M.D., M.P.H., STATE HEALTH OFFICER, ALABAMA DEPARTMENT OF PUBLIC HEALTH, MONTGOMERY, AL [1]

Dr. **Fox**. Thank you, Senator. I appreciate the opportunity to testify representing the State Health Officers Association on the Year 2000 Objectives, and we also appreciate your interest in this, what we consider a very important subject. Preliminary to answering the comments or the questions that were provided to me previously, I would like to make a few statements about the Public Health Foundation that was established by the State Health Officers Association several years ago. That foundation has developed over the last several years a mechanism whereby they can document levels of activity in various program areas as well fiscal information that we have reported across the states. These reports have been helpful to us as State administrators. We have provided the information to Congress and to other groups over the years, and the information has also been published in chart books and other annual reports and newsletters.

Recently we have noticed the trend—and I think it is a very important and valid trend—to move toward focussing on national public health priorities and also on outcome data. We started looking at our objectives and our reporting situation relative to trying to develop a uniform national data set that would, related to certain stated objectives, permit valid observations between the states. Of course, this was a recommendation cited in the Institute of Medicine Report on the Future of Public Health. This identified need spurred recently a considerable amount of activity in the Public Health Foundation which led to the convocation of a number of work groups to establish minimum data sets that would address nine of the goals or areas encompassed in the Year 2000 Objectives. There were a number of parties that worked on these. The Association of State and Territorial Health Officers, CDC, State and Territorial Epidemiologists, the National Center for Health Statistics, and others. We have, and I will make available to both the members of the Committee and staff, this draft of the data for the Year 2000 National Health Objectives from the reporting system. This is the initial chart book, and I think it is going to provide a lot of useful information.

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[1] See p. 63 for Dr. Fox's prepared statement.

The framers of the Year 2000 Objectives certainly demonstrated their understanding of the importance of monitoring progress by including a separate section toward the end of that document on surveillance and data needs, and in addition, have included at least one, and in many instances more than one, data related objective in each one of the 20 priority areas.

In summary, there is a shared commitment, we feel, to data collection and information systems which with the proper fiscal support—and I want to emphasize that—can allow us to move rapidly toward a state of the art response network.

I now want to respond to the specific questions provided to me earlier. First, in reference to the validity of the Year 2000 Objectives, I would like to commend the authors of the draft, Mike McGinnis and others, for their extensive efforts to involve Federal, State and local individuals throughout this country to establish those objectives that were selected in the publication. They visited a number of states, a number of sites, and worked with a number of individuals to get adequate input. Several drafts of this document have been circulated to us and other individuals for comment, and while this document is certainly not all-inclusive, there obviously has been a monumental effort in developing and refining the objectives, and I understand the final document that will be published and released in September will be even more well developed.

In addressing the issue of whether or not the objectives are measurable, I think one must look at 2 definitions of measurability. The first requires some baseline data from which to assess progress. The latest draft points out that 110 of the objectives, or about 30 percent, in fact do not have baseline data, and about 28 of the special populations have no baseline data at all. After much deliberation and prior to development of the objectives the decision was made to purposely include objectives which reflect priority public health problems despite the fact that no baseline data exists. Failure to include these objectives we feel would create a false impression that certain emerging problems were of less importance. I want you to note the fact that in 1980 we have virtually no baseline data on AIDS, on crack and cocaine use, and there were no states that I know of in 1980, or maybe in 1985 very few, that were reporting any information on HIV positivity status, and now 20 plus states report that information. So we feel that it is certainly of paramount importance to keep these items in the document.

The second definition of measurability might be that which lends itself to form of measurement, and I think we certainly feel that most of the objectives in the document are measurable by that definition, either through direct or by surrogate methods.

The second question I was asked to address is whether or not nationwide disease prevention efforts would be aided by publication of nationwide objectives. I must say that the reviews on the impact of the 1990 Objectives indicate in many instances disappointment at the failure to attain some of those objectives, and I think about 50 percent of those objectives were attained. However, I believe there is universal agreement among the public health community that establishment of the objectives was useful both in terms of setting targets for program management, and also in allowing for states to have comparison among themselves. For example, a southern governors association's major initiative in infant mortality was entitled "Nine by Ninety," a direct reflection of the infant mortality goals in the 1990 Objectives. Personally, I found the draft of the 2000 Objectives which I have studied to be better framed than those for 1990, as stated earlier. Our needs for improved data collection efforts have been highlighted during the past decade.

I have been asked how State and local agencies are affected by immigration and population shifts; certainly in planning for a decade of public health services one must look at times that predictably or unpredictably there are influxes of individuals who may need services and overload the system. The most glaring example, obviously, being in California with the Mexican nationals, also in Florida with the Cuban refugees and others. In short, both individual states and the Federal Government must closely monitor these programs and accommodate them with programs such as the state legalized impact assistance plan that has been administered by DHHS. These grant dollars were appropriated to augment states to provide services, preventive health services and others, to the individuals who became citizens during such shifts from say Central and South America. Several States received these grants.

The next question asks are data available or attainable at state and local levels to monitor the progress toward the Year 2000 Objectives. In late 1989 the Public Health Foundation conducted a survey of the states which posed this question of availability. A response was asked for each objective in each of the 21 priority areas, including the draft objectives, some 637 objectives, including the ones to minority populations, in all. Thirty-nine States completed the questionnaire for all 21 areas, and an additional nine States responded to 15 of those areas. Preliminary analysis of the responses revealed that priority areas for which data were most frequently available from the states include preventing unintentional injuries, reporting infant and maternal health, reducing sexually transmitted diseases, and improving surveillance and data systems.

On the other end of the spectrum, States were able to provide data for only about 30 percent or fewer of the objectives in five of the areas, including improved nutrition, increasing physical activity, maintaining the vitality and independence of older people, improving oral health, and improving education and preventive services. Further analysis of the data will allow us to determine potential regional variations in state data collection capabilities and variations between the availability of data for process and outcome objectives and the difference in the availability of data for minority populations.

I would like to also ask that we remember that national sampling surveys can often provide excellent and reliable information and although sometimes expensive may be much less costly that universal counts. For example, the already cited National Health Interview Surveys conducted by the National Center for Health Statistics are of prime importance and often provide data where no other information exists. Also, we benefited greatly in Alabama from information provided through the knowledge and belief surveys for which our staff was trained by CDC, and we found that quite useful. Our findings have been helpful in such hard to measure areas such as health education.

The compatibility of State and local data within the Year 2000 Objectives, when viewed from the health outcomes perspective, runs the gamut from an unequivocal yes to the need to rely on proxy data. Obviously, some objectives are measurable by vital event, date of birth, death certificates, et cetera, such as the infant mortality rate. Other objectives require an analysis of the data prior to drawing a conclusion regarding the process. I must reemphasize the importance of the flexible climate in which the objectives were developed with a basis on looking at priority public health needs rather than conveniently looking at only those objectives that would relate to existing or direct data sets.

The final issue I was asked to address related to the ability of the States to issue yearly checkups using national data for comparison. The answer to that question would depend really on the technique of measurement used and when during the year reports would be due. For example, to determine the increase in the percentage of persons using food labels to make selections on a national sample survey compared to a sample survey in each of the individual States, this might be fairly easily attained, if somewhat expensive. In other areas, such as looking at the reduction of homicides, the national data is a compilation of State data, and obviously, national data lags behind due to time needed for preparation and submission of accurate reports from the States. The quickest the national data could be available would be only as fast as the slowest State, because all States would have to report. Consequently, a format which allows for reasonable time frames for the reporting process would be important. One mechanism through which States are able to report on uniform data again is the Public Health Foundation which I have already cited, and again, the National Health Interview Survey reflects the national picture for many of these objectives.

That ends my response to the specific questions provided. I would like to make just a few other points prior to ending my formal testimony if I could. One, the public health community strongly supports the concept that accountability must be a component of the service delivery system, and as good stewards of the taxpayers' dollars we are committed to improving our capability in that area.

Second, the technology for the information age has vastly improved our ability to collect and analyze data, but it begs that we exercise prudent judgment in our definition of data needs so that each level of management—local, State and Federal—has the information needed to make intelligent decisions without collecting expensive but superfluous information.

Third, the reliability of data generated at the local level is directly proportional to the worth of information returned through the feedback loop and its usefulness for day-to-day program management by local staff.

Fourth, there is probably always going to be a cutting edge set of problems in public health for which no baseline data is available. Consequently, the development of data sets is an evolutionary and ongoing process.

Fifth, some important objectives will only be measured by surrogate data with corollaries established by studies in the public health body of knowledge.

Sixth, the development of data sets where they are needed must recognize a variety of data collection and analysis techniques, some uniform counts, some surveys, et cetera, and should make sure that there are valid and reliable data at the least cost.

Seventh, the Federal investment in data collection efforts such as those operating now through the National Center for Health Statistics should be continued as they are a critical component of the information network.

Eighth, the establishment of health objectives for the Nation is most useful as a blueprint for preventive health activities which helps to crystallize certain priority areas and allows again for State to State comparisons.

Ninth, each of the States has unique characteristics—and I would like to emphasize that—and capabilities which must not be ignored as any national effort is undertaken. And I might say, in the previous question regarding the right priority ranking, this certainly would be a mechanism to do that and it might be useful, but some states are going to have more problems in AIDS, other States are going to have more problems in infant mortality, some are going to have more of a problem in environmental hazards, and I think that the funding mechanism for any dollars coming from Congress should take that into account.

And finally, as we move rapidly toward the unveiling of the Year 2000 Objectives, the Association of State and Territorial Health Officials and the public health community submit to you that regardless of the quality of the document written, the States' ability to mount aggressive campaigns to achieve the objectives will require additional resources. I will refer you to Senate Bill 2056, introduced by Senator Harkin and supported I know by you, Senator Bingaman, which would provide dollars to the States to allow for new and expanded services directly related to the Year 2000 Objectives, including those objectives related to improved data systems. Obviously, you know that $540 billion is spent in this country annually on health area and less than $2 billion is spent on preventive health services. The tragedy of this statement lies in the fact that for every dollar spent in preventive services we are able to favorably impact the overall expenditure of health dollars.

With additional resources to achieve the objectives of the Year 2000 and funds which we are able to generate from other sources, I feel that significant progress can be made during the next decade, both in service delivery and in our ability to document and assure that our activities are indeed enhancing the quality of life for Americans.

Thank you.

Senator **Bingaman**. Thank you very much. There are a couple of things that you alluded to in your prepared statement, that I would like to run past.

We have been thinking that we should have a requirement on an annualized basis throughout the 1990s that we should have a checkup issued or published. The check up would show how well we are doing as a Nation but also how well each State is doing in making progress toward a limited number of those goals. It would be understandable and comprehensible to the public and could be tracked based on our present capabilities.

Does that make sense to you? Is that something that should be done nationally, and if so, should we try to bring it down to a State basis so we could have comparisons from State to State?

Dr. Fox. Senator, I think that would be very useful. I do believe if we do that we ought to bring it down to State, and probably even sub-State levels. Because, for instance, with the issue of infant mortality, we might say that five States have a problem with infant mortality, but if you start looking at the detailed indicators at the local level, one State may have a problem in that they don't provide prenatal care, another State may have a problem in infant mortality because they don't have access to hospital delivery services. So I think that the indicators would certainly help us target or red flag areas where we have a problem, but I would say that if we do that, let's make sure that there is some mechanism to look at that in more depth so that we can actually come to some of the epidemiology behind why the problem exists and develop some intervention strategies to try to deal with it.

Senator Bingaman. But you think just having an annualized report on how we are doing State by State would help focus people's attention on the areas that we need to address even if it didn't tell them exactly how to get there?

Dr. Fox. I think that would be helpful, yes.

Senator Bingaman. You alluded also to the idea of setting priorities or picking out of this whole large array of areas where progress is needed, those areas that are most important or most cost effective or hold out the greatest promise of improving the health of the majority of the people.

If we were to ask the Federal agencies to make that kind of determination and advise us as to which areas do hold out the greatest hope for improving the health of the most people, would it be reasonable to urge States to do the same thing. To ask each State to set its own set of priority areas that it would then use in allocating Federal dollars that it receives?

Dr. Fox. I think that would be an excellent approach. In fact, the National Health Objectives Act I believe has a mechanism for the Secretary to establish some areas, but then each State would develop its own plan based on individual needs within the State, and those, obviously, would vary by State. So I think that you have to have some State individuality where the problems would be developed in particular relating to what the problems were in that State.

We feel like that would be helpful. I have struggled with the whole issue of setting priorities in various programs in my 16 years in public health, and rather than going to high and low priorities, we have thought about the idea of using certain critical indicators, because if an indicator or a program is categorized as low priority, often that means no priority so it doesn't get addressed at all. But I think to have some critical key indicators that could be looked at and then have the States, if they feel that they have a particular problem in their own State that maybe is not reflected in the national indicators, that that could also be looked at.

Senator **Bingaman**. In the Armed Services Committee on which I serve, we have tried to focus their research and technology development dollars in areas of critical need for the long term security of the country. Essentially what we are talking about here is focusing our public health dollars in the areas of critical need for the long term health of the country in the same way.

Now, my sense is that that is not being done very well today. Am I wrong?

Dr. Fox. I think you have it done on a case-by-case basis. For instance, CDC looks at their programs, DHHS looks at theirs. I don't know that there is a coordinated effort that is going on where any one person or entity is looking at all of them. Perhaps that is the case and I am not aware of it.

Senator **Bingaman**. There is no national agreement as to what the most critical areas are for the country as a whole?

Dr. Fox. Not to my knowledge.

Senator **Bingaman**. Okay. Well, I think your testimony has been very useful. We appreciate your coming today and sharing it with us, and I think these two hearings have been useful for the Subcommittee, and we will try to follow-up on some of the recommendations that have been made.

Before I conclude the hearing, I would like to give special recognition and thanks to Bob Moore who is on detail to our Subcommittee Staff from the Department of Health and Human Services. Bob is participating in the Federal Government's legislative fellow program and has been responsible for putting these hearings together. Bob has done an excellent job, and I am appreciative of his contribution, and of HHS for allowing him to work with us.

Thank you very much. The Subcommittee is adjourned.

[Whereupon, at 11:20 a.m., the Subcommitee was adjourned subject to the call of the Chair.]

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

STATEMENT

BY

JAMES O. MASON, M.D., Dr.P.H.

ASSISTANT SECRETARY FOR HEALTH

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT INFORMATION AND REGULATION

COMMITTEE ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

MARCH 20, 1990

Thank you, Mr. Chairman. I am pleased to be here today to discuss our National Health Promotion and Disease Prevention Objectives for the year 2000.

Background and History of the Year 2000 Objectives Initiative

The Year 2000 Health Objectives initiative builds upon our experience over the past decade in using a management-by-objectives process to set out a strategy for using health promotion and disease prevention to improve the health status of the American people. In 1980, the publication of *Promoting Health/Preventing Disease: Objectives for the Nation*, set forth 226 measurable objectives, arrayed across 15 priority areas for preventive interventions, with targets to be achieved by 1990. The 1980 document was the first comprehensive approach using management-by-objectives to frame and then monitor progress on a national level related to preventive health.

During the 1980s, as we worked to bring more participants at State, local, and national levels, into the health objectives program, we began to use the objectives as the kind of management tool that had been originally envisioned for them. The Assistant Secretaries for Health convened monthly "progress reviews" attended by the responsible Public Health Sere agencies, together with related agencies within the Department and beyond, to account for progress made toward their achievement. We are now in the fourth "round" of progress reviews since they began in 1981.

It is instructive to note that, by the time of our midcourse review in 1985, we had already achieved about 13 percent of the 1990 objectives by 1985; we appeared likely to achieve an additional 35 percent. It seemed unlikely that we would achieve an additional 25 percent; and we lacked data to assess the status of the remainder. Significant improvements had occurred in areas such as unintentional injuries, childhood immunizations, smoking behavior, and stroke deaths. Though progress was slower than we might have wished for others, all but eight of the objectives were moving in the right direction. The areas of greatest difficulty had their roots in behavioral and social issues, not just biomedical ones, including such issues as teen age pregnancy, low birth weight, and illicit drug use. The data problems that were uncovered through the objectives-monitoring process related in some cases to poorly defined objectives that, in effect, eluded measurement, to changes in program structure as in the case of block grant programs that made measurement unfeasible.

It is important that I pause to note here what I mean by the pronoun *we*. From the beginning, we in the Public Health Service made clear that any health promotion and disease prevention effort could only make real sense if it was a national effort, rather than just a Federal one.

The Year 2000 Objectives

In 1987, we began the process that will culminate this September (1990) in the publication of a revised set of objectives to guide our health promotion and disease prevention efforts during the 1990s. The Year 2000 health objectives will be published under the title, "Healthy People 2000," recalling their historic links to the original report in 1979. This process has involved a much more extensive, grassroots approach than was the case in the development of the objectives for 1990. There have been five separate phases to the developmental process:

- Planning phase (1987), with the organization of a consortium of over 300 national membership organizations and State health departments to act as partners with the PHS in this effort, and polling of State health leaders about the process itself.

- Public Input (1988), during which the PHS with its principal partner, the Institute of Medicine of the National Academy of Sciences, hosted regional hearings across the country and at forums held in conjunction with national membership organization's annual meetings, in order to get over 750 submissions of professional and consumer testimony regarding the substance and the form of objectives for 2000.

- Drafting Objectives (early 1989), during which 21 work groups, led by PHS "lead agencies," addressed the priority areas defined as the framework for preparing the new set of objectives, drafted new objectives with explanatory commentary and engaged several thousand experts in the first review of their drafts.

- Public Review and Comment (late 1989), when 13,000 copies of the entire set of objectives with commentary were published for extensive review and comment. The draft objectives addressed 21 priority areas for preventive interventions, organized under headings of health promotion priorities, health protection priorities, preventive services priorities, and system-improvement priorities (see chart).

- Final Revisions and Publication (1990), the phase in which we are currently working to prepare final objectives, write the "Healthy People" introductory material, and publish in time for a release at a national conference to be held in Washington on September 6 and 7, 1990.

I think that those of us who have been deeply involved in this process feel that, in many ways, it may be the most extensive, comprehensive, and open experiment in democratic health policy-making undertaken to date in the United States. Given the extensive memberships of the consortium organizations, the State health departments' involvement, the many experts who have freely given their time and thought, and the dedicated staff within the agencies of the PHS, the final strategy that is released next September will clearly be the result of a national effort. Many individuals, organizations, and levels of government will have investments in its effective implementation.

Are the Objectives Attainable and Measurable?

From the beginning of the development process, a set of criteria has governed the objectives. Chief among these criteria are *measurability* and *realism*. We are not engaged in a rhetorical exercise, stating only for purposes of motivation or encouragement a list of hopes or wishes for the future. In keeping with the basic philosophy of management-by-objectives, the quantified targets that are being set for attainment by 2000 are meant to be taken with the same kind of seriousness that business people take their production and sales targets.

One of the lessons from the 1990 objectives is that those few objectives that were not clearly measurable had little utility. Only if we are able to define where we are and where we want to go will we be able to mark our progress. Without such definition--which means without measurements--objectives become an exercise in aspiration rather than an exercise in management to achieve improvements.

Measurability does not, however, mean that we have to forego setting targets that address subjects for which we lack existing quantified baseline data. Rather, it means that we must be able to measure, even if we have not yet done so.

Based on the draft objectives, most of the health status and risk reduction objectives are currently measured by annual or periodic surveys, most of which are conducted by PHS through ongoing surveillance and sample survey programs. A subset of objectives, particularly those that address the extent to which services are provided, do not have currently available baseline data and will require special surveys to begin measurement toward their attainment.

Resources Needed for the Year 2000 Objectives

You ask if further resources will be needed to promote or to monitor the objectives. In general terms, the answer is yes, but I cannot say whether that means additional money. The very nature of the objectives process implies that more effort is needed in certain areas, but it also implies that goals should be more readily met through focused activities. The purpose of the objectives, beyond serving as a management tool to measure progress as it occurs, is to serve as a catalyst for change, as an energizer of various relevant sectors of public and private sectors, as a framework for decision-making about fiscal resource allocation.

More is needed to support prevention--more personal investment on the part of Americans whose lifestyles affect their risks of chronic disease, long-term disability and premature death; more professional attention to preventive interventions that can reduce the need for expensive, painful therapies; more public and private financial resources aimed at supporting healthier environments and healthier decisions, especially among those who because of low income, minority status, age, or gender are at highest risk.

Fiscal resources to support the year 2000 objectives are clearly not unlimited, whether we are talking about Federal and State public funds or those available to employers to support health promotion and disease prevention at the workplace or those available to individuals. We think that one important aspect of these objectives, however, will be their utility in defining opportunities where fiscal investments will bring the highest returns in individual health and long-term savings. In addition, these objectives help us to recognize that improvements in health are determined by the appropriate use of resources that are usually not considered part of our health care expenditures, such as resources for transportation, recreation and leisure, consumer product marketing, communications media, agriculture, and many other elements of our commonwealth.

A National Check-Up on the Year 2000 Objectives

Your question about an annual check-up on the Nation's health, using the year 2000 objectives is a provocative one. In fact, we plan for "Healthy People 2000" to provide a set of about 25 "summary" or "flagship" objectives that can be used to tell us about the Nation's "vital signs," to continue your health check-up analogy. It may be that not all of these objectives will involve data that are collected annually, but many of them will, including progress made against chronic diseases, unintentional and violent injuries, infectious diseases, and other aspects of health status.

A Model for State and Local Health Agencies

Already we are working with organizations representing State and local health departments to ensure that the national health objectives can serve as an effective model for them in development of State and local health promotion and disease prevention strategies. You will hear later from Charles Stokes who is chairman of the Model Standards Coordinating Committee, representing four national organizations that developed a set of standards to guide the work of State and local health agencies to set their own targets. For the last year, we have been working in concert with the Model Standards Coordinating Committee, and that group plans to publish later in 1990 a new version of its model standards for community programs, in the form of a workbook that uses the year 2000 objectives as its template. This workbook will assist States and localities as they take the national objectives to the community level where the changes envisioned in year 2000 targets must actually occur. We are also hopeful that many States will follow the lead of such States as Missouri and Oregon and will develop their own specific year 2000 plans, choosing from the array of priorities and objectives in the national document. Many States have already informed us of their intention to do just that.

The Federal Government as Model

Your final question raises the issue of the Federal government addressing the kinds of improvements for its own employees and programs that the year 2000 objectives calls upon the whole Nation to undertake. The Federal government is an employer, a health insurer, and a health care provider. In all of these arenas, there will be room for the kinds of improvements envisioned by the year 2000 objectives. Some of the improvements are already beginning.

For example as employer, the Federal government has begun seriously to support development of health and fitness programs by its various agencies. A current project, collaboratively supervised by the Office of Personnel Management and my office in PHS and implemented by the Association of Schools of Public Health, is developing a qualitative evaluation of selected sites where such programs have been most fully developed for use as guidance to agencies that are only at the first steps in organizing such efforts. One of the sites being reviewed, Mr. Chairman, is the Federal establishment at Los Alamos, New Mexico.

As insurer through its Medicare and Medicaid programs, there are clearly some difficult policy decisions to be made in the coming years about the appropriateness and effectiveness of reimbursement for preventive services. Major improvements have occurred recently in extension of coverage for prenatal care, one of the most important of our preventive interventions and a key objective in the year 2000 plan. Demonstrations are looking at issues of feasibility and effectiveness of packages of preventive services for Medicare recipients. The Executive and Legislative branches of the Federal government will have important decisions to make as they consider in the coming years the ways that these Federal health insurance programs can and should support our achievement of the targets we have set for the year 2000.

As health care provider through such programs as the Indian Health Service, I can only say that the Federal government is already leading the way. IHS hospitals were the first in the Nation to be smoke-free hospitals. An IHS health promotion and disease prevention initiative, based in Albuquerque, has engaged all of the tribal nations in planning that goes beyond the clinic and reaches into

Indian schools and communities with programs aimed at the prevention and control of diabetes, alcohol abuse, safety, and other important areas of prevention.

In short, Healthy People 2000 does not discriminate. It is meant for all the American people, whether publicly or privately employed, whether enrolled in public or private insurance programs, whether receiving health care services from private providers or public clinics.

Conclusion

Mr. Chairman, I have briefly described the background and process of developing health promotion and disease prevention objectives for the year 2000 and responded to the questions that you posed in your letter of invitation to the Secretary. I will be happy now to respond to any additional questions that you may have. Thank you again for this opportunity.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

MAY 15 1990

The Honorable Jeff Bingaman
Chairman, Subcommittee on Government
Information and Regulation
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Bingaman:

I appreciated the opportunity to testify before the Subcommittee to discuss the Year 2000 Objectives for the Nation. The following are responses to the questions in your March 30 letter:

1. Question: The "flagship" objectives were frequently mentioned. What objectives will be specified as "flagship" objectives, and will data be available on an annual basis? Also, would these "flagship" objectives be considered the most important?

   Response: Flagship objectives would be a short list of priorities that provide greater focus to the national health goals and the year 2000 objectives. We in the Public Health Service are still deciding, with the advice and consultation of many experts, what this priority list will be.

2. Question: There seems to be a shortfall of resources within the National Center for Health Statistics. What areas within the NCHS will most likely absorb the shortfall in order to remain within the 1991 President's budget? How much more would have to be available to NCHS over the FY 1991 President's Budget, to fully fund all NCHS functions necessary to establish baselines and monitor progress toward the Year 2000 objectives?

   Response: As you note, the FY 1991 President's Budget for NCHS will not enable us to support all worthy NCHS activities. At this time, the Administration has not determined which of the NCHS's activities will be delayed.

   Overall, we would have to make approximately $9.4 million in additional funding available to NCHS in order to conduct all its worthy projects, including all activities related to establishing baselines to monitor progress toward the Year 2000 Objectives.

3. Question: In the event that a decision is reached to suspend the National Health Interview Survey (NHIS) for one year or more, are provisions being made to provide State and local health departments with the data they normally obtain from the NHIS? Would States have to develop their own survey instruments to obtain data that would have been available through the NHIS?

   Response: States use the NHIS in several ways. The NHIS is used as a national "reference," providing a context for the interpretation of more detailed data collected by an individual State. For example, a State can compare its own experience to national averages. If a State has not collected its own data, a general idea of conditions in an individual State can be obtained by constructing models based on national data. These models adjust data from the NHIS to account for a State's particular demographic profile (e.g., age, race, sex).

   We do not provide direct estimates of a State's health through national sample surveys like the NHIS, because the sample size of such surveys is not sufficient. Through data collection geared to monitor health issues of priority to the State, many States do collect such information. For example, 45 States participate in the Centers for Disease Control's Behavioral Risk Factor Surveillance System, a State-based telephone survey for monitoring many of the risk behaviors that relate to the Year 2000 Objectives.

   We continue to assess survey plans for 1991 and we have not yet fully addressed the extent to which we would be able to provide data from other sources to States for the reference and modeling uses described above. In the event that the 1991 NHIS were not conducted, some States may be able to use data from the 1990 NHIS supplement on health promotion and disease prevention, which covered some of the topics that would have been covered in the 1991 NHIS.

Thank you again for the opportunity to testify before the Subcommittee.

Sincerely yours,

James O. Mason

James O. Mason, M.D., Dr.P.H.
Assistant Secretary for Health

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Centers for Disease Control
Atlanta GA 30333

STATEMENT

by

MANNING FEINLEIB, M.D., Dr.P.H.

DIRECTOR

NATIONAL CENTER FOR HEALTH STATISTICS

CENTERS FOR DISEASE CONTROL

PUBLIC HEALTH SERVICE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS

SUBCOMMITTEE ON GOVERNMENT INFORMATION AND REGULATION

UNITED STATES SENATE

March 20, 1990

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I appreciate the opportunity to appear before you today to discuss the Health Objectives for the Year 2000. I am Manning Feinleib, M.D., Dr.P.H., Director of the National Center for Health Statistics (NCHS), a component of the Centers for Disease Control (CDC). I also serve as Special Advisor on Health Statistics to the Assistant Secretary for Health.

In his testimony, Assistant Secretary Mason has provided you with the broad outlines of the purpose of and process for developing the Year 2000 Objectives. This process has provided the occasion for a structured review of our public health priorities, and, by extension, for considering the adequacy of the information base that allows us to understand and address the health problems of our Nation. From the point of view of the Nation's health statistics effort, this process has served two important purposes: first, to focus attention on the importance of data in all of our public health initiatives; and second, to direct the focus of our data systems to more clearly define public health priorities. I will speak to you in somewhat more detail on the implications of these Year 2000 Objectives for our nation's health data systems.

I am looking forward to joining Secretary Sullivan in several days for the release of Health, United States, 1989, the Secretary's annual report to the Congress on the Nation's health. This year's report included the Prevention Profile, our triennial "scorecard" on progress in meeting health promotion/disease prevention objectives. Although this report highlights the role that data from NCHS and other sources have played in the 1990 Objectives process, the proximity of its release to this hearing points out the larger job ahead of us in meeting the data requirements of the Year 2000 Objectives.

Data Needs for National Health Objectives

Responsibility for identifying and providing data for monitoring the Year 2000 Objectives is shared by agencies throughout the government, in State and local governments, and in the private sector. Each of the health priority areas outlined in the draft Year 2000 Objectives provides an assessment of the availability of data for establishing baseline measures, and potential data sources for tracking progress. For each of these priority areas, an agency within the Public Health Service has been assigned lead responsibility for all aspects of the objectives. CDC will assume lead responsibility or share lead responsibility with another agency for half of the priority areas.

In developing objectives, interagency working groups operated under two data-related guidelines. First, all objectives were to be quantified and measurable in order to allow an assessment of progress. Second, although objectives were to be measurable in principle, the current availability of data was not to be a primary consideration in determining the nature of the objectives. Each objective spells out tracking requirements and identifies data sources if available. We anticipate that most of these data needs can be met through existing data systems (or modifications); however, if needed, new data collection efforts will be undertaken.

Our most immediate task is to identify and provide data needed for establishing baseline measures in each of the objective areas. As Dr. Mason indicated, these priority areas and objectives are currently undergoing revision based on public comment. As a result, we are unable to provide a precise estimate of the extent to which we have baseline data for the final objectives. Based on a review of the draft objectives published for public comment in September 1989, it is estimated that baseline data exist for about 70 percent of the objectives. We are also unable to estimate at this time the extent to which we will be able to identify data sources for tracking the objectives - in part because the objectives are under revision, in part because survey plans for the next several years have not been finalized. The process of drafting objectives led to a broad recognition of the need for improvements in our Nation's "infrastructure" of public health information; at the same time, the Institute of Medicine's report The Future of Public Health emphasized the need for improvements in our ability to assess the health of the American people. To address these needs, a priority area has been included in the Year 2000 Objectives: a set of explicit objectives to improve surveillance and data systems. I will describe some aspects of this priority area in a few moments.

Sources of Data

Data systems of CDC, including NCHS, will assume a large share of the responsibility for establishing baseline measures and for tracking progress in meeting objectives. CDC will have lead responsibility for objectives included in the surveillance and data systems priority area. As the nation's principal health statistics agency, NCHS will provide data from national surveys for many of the objectives, work with other lead agencies to meet data needs of individual objectives, and provide overall coordination of tracking and monitoring progress.

NCHS data systems address the full spectrum of concerns in the health field from birth to death, including overall health status, life style and exposure to unhealthful influences, the onset and diagnosis of illness and disability, and the use ofhealth care and rehabilitation services. NCHS maintains over a dozen surveys - for example, the National Health and Nutrition Examination Survey and the National Vital Statistics System. These surveys collect health information through personal interviews; physical examination and laboratory testing; review of hospital, nursing home, and physician records; and other means. Although NCHS is responsible for meeting a multitude of data needs unrelated to the Year 2000 Objectives, most NCHS data systems include data relevant to the objectives. We have also made several special efforts to collect data directly related to the 1990 objectives.

CDC also maintains over 100 surveillance systems which collect, analyze, and disseminate timely data on a broad array of public health conditions. These surveillance systems address infectious, chronic, occupational, and environmental diseases; intentional and unintentional injuries; and personal risk factors. Usually the product of close collaboration between CDC and States, these systems provide the information required to assure that timely information is available to allow effective public health action. In addition, many of these systems will provide data for monitoring the Year 2000 Objectives.

Finally, we are working with a number of other Federal agencies (e.g., the Department of Education, the National Highway Traffic Safety Administration, and the Bureau of Labor Statistics) which maintain data sources that will be valuable in monitoring objectives. Similarly, data available from private and professional associations will be used to augment data from Federal surveys.

Challenges in Meeting Data Needs

One of the important purposes of the Year 2000 Objectives is to challenge public health officials to new achievements. In each area, these objectives call for accomplishments beyond what would be expected in the absence of the focus provided by the Year 2000 Objectives process, and beyond what is attainable with current efforts.

Meeting the data needs of the nation, and for the Year 2000 Objectives, offer challenges as great as those found in any of the individual health objectives. If we are to meet these challenges, we will need concerted efforts by NCHS and by our partners in other CDC units, other Federal agencies, State and local health agencies, and professional associations.

Among the most important challenges:

- **Measuring the health of special population groups.** Morbidity, mortality, access to and use of health services, and health behavior vary markedly by age, race, sex, and socioeconomic status. Recognizing these differences, many objectives have special population targets for minority groups (e.g., to reduce smokeless tobacco use among American Indians/Alaska Natives). In many cases, however, there is little or no data on these groups.

- **Developing approaches for measuring objectives not measured at baseline.** Of the objectives for which there are no baseline data, there are two primary types: first, those for which existing survey mechanisms can be modified or expanded to provide data; and second, those for which no mechanism now exists that can be readily adapted to provide required data. Where appropriate and necessary, existing data systems need to be evaluated and modified, priorities changed, and new approaches developed.

- Improving access to data for tracking the Year 2000 Objectives. Despite limitations, data for many of the objectives *are* currently available from existing data sources. However, these data are not always in forms readily accessible to public health officials at the national, State, and local levels. Further efforts are necessary to improve electronic access to data and to make data available in a form that can be easily used.

- Maintaining the viability of existing data systems that provide data to track the Year 2000 Objectives. Potential data sources have been identified for a majority of the objectives. We are committed, to the maximum extent possible with the resources available to us, to maintaining the scheduled data collection for national surveys during the decade to monitor these objectives adequately.

- Improving data at the State and local levels. Even if data were available for tracking all of the objectives at the *national* level, our job is less than half done. Inherent in the approach to the Year 2000 Objectives is the central role of State and local public health officials in adopting objectives of highest priority in their own jurisdictions. Indeed, achieving goals at the national level rests upon the success of State and local officials in effectively targeting and implementing intervention programs. State and local officials need data on the health profile of their jurisdictions if they are to be successful in this effort.

Initiatives in the Surveillance and Data Systems Priority Area

Many of these challenges are not new, and it is likely that challenges will remain at the end of the decade. However, the inclusion of explicit objectives for the improvement of surveillance and data systems in the Year 2000 Objectives ensures that the attention of public health officials will be directed to meeting these challenges over the next decade.

The intent of the objectives in this priority area are to:

- Assure that data are obtained for all national objectives (including population subgroups, where needed).
- Develop standard methods that can be used at the national, State, and local level to produce comparable data for monitoring the objectives.
- Assure that each State collects and analyzes data for at least half of the priority areas.
- Develop a system for rapid transfer of data and other health information related to the Year 2000 Objectives.
- Assure timely access to available data.
- Develop a set of health status indicators that can be used to assess health by agencies at the national, State, and local levels.

This is an ambitious agenda that will require concerted efforts of the private sector, State and local governments, and the Federal government between now and the year 2000. We have already taken the first steps, initiating detailed reviews of existing data bases (both Federal and otherwise) and their ability to meet identified data needs. We have also begun to put into place the coordinating mechanisms that will be required for tracking and monitoring the objectives, and for addressing initiatives in the surveillance and data systems priority area.

Conclusion

As I have outlined, we are committed to develop, to the maximum extent possible with the resources available to us, the data systems needed to fully address the Year 2000 Objectives. We look forward to the significant challenges in addressing all of the implications of this process. The explicit attention given to surveillance and data systems as part of the Year 2000 Objectives process is an encouraging sign that important needs for data on our nation's health will be addressed over the next decade.

I WOULD BE HAPPY TO RESPOND TO ANY QUESTIONS THAT YOU HAVE.

STATEMENT OF

DR. JOHN F. MAZZUCHI, Ph.D.
PRINCIPAL DIRECTOR
PROFESSIONAL AFFAIRS AND QUALITY ASSURANCE
OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

ON

PROMOTING HEALTH / PREVENTING DISEASE: YEAR 2000 OBJECTIVES FOR THE NATION

BEFORE THE
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS
SUBCOMMITTEE ON GOVERNMENT INFORMATION

101ST CONGRESS, SECOND SESSION

MARCH 20, 1990

Not for Publication
Until Released by the
Subcommittee on Government Information
Senate Committee on Governmental Affairs

Mr. Chairman, Members of the Committee:

I appreciate very much the opportunity to appear before this Subcommittee to discuss the Department of Defense's health promotion program and the proposed "Promoting Health / Preventing Disease: Year 2000 Objectives for the Nation." I applaud your interest and dedication regarding issues related to our nation's health promotion effort. I also acknowledge Senator Bingaman's special role in helping the Department of Defense launch its major health promotion initiative in 1986.

As requested, my testimony will address each of the questions raised in your letter of invitation, focusing on the "Year 2000 Objectives for the Nation."

1. Are the proposed Year 2000 Objectives valid, realistic, and attainable?

The proposed Year 2000 Objectives for the Nation provide a broader focus than that of the Department of Defense, but certainly one that is compatible with our health promotion efforts. We believe that the objectives of this plan are indeed realistic, valid and attainable.

In his first appearance before the Congress as the Assistant Secretary of Defense for Health Affairs, Dr. Enrique Mendez, Jr., stated that he will "continue to advocate health promotion actions on the part of military personnel." The Surgeons General of the Army, Navy and Air Force joined Dr. Mendez in expressing their personal commitment to health promotion and disease prevention efforts.

These efforts were refocused and strengthened in 1986 with the publication of Department of Defense Directive 1010.10, "Health Promotion." The Directive reflected the recommendations of a special Blue Ribbon Panel convened at the request of the Congress to examine the Department's health promotion effort. It established policy to encourage not only military personnel, but also their families and civilian employees, to live healthy lives through an integrated, coordinated and comprehensive health promotion program. The program focuses on six areas: nutrition, smoking, alcohol and drug abuse, stress management, physical fitness, and early identification of high blood pressure. The overall program reflects the present Objectives for the Nation and targets community, work site, internal mass media and clinical opportunities.

2. What would be required for the federal government, as employer, insurer and health care provider, to implement the recommendations of the Year 2000 Objectives for the Nation report makes for private organizations?

Government agencies can frame basic policies and programs for their employees that meet the spirit of these objectives, promote a healthy lifestyle, and assist in health risk reduction. There are a myriad of both federal and private organizations from which to obtain both health education materials and services at a minimal cost. The role of the federal government should be to make these resources known and available to its employees and to create an atmosphere that is conducive to good health.

The Department of Defense health promotion policy applies to military personnel and to civilian employees. The Department believes that the work site offers an effective opportunity for these two groups. Our internal media resources disseminate health promotion information through multiple announcements in the press and publication service and radio and television spot announcements. The early identification of high blood pressure, for example, is a significant part of the DoD health promotion program. The Department of Defense actively supports National High Blood Pressure Month. Blood Pressure screening is available to civilian employees through the occupational health clinics and special health fairs, and to military personnel through the military medical and dental care channels. Military communities often work with and take advantage of local resources to enhance the overall effort. Cholesterol screening and smoking prevention and cessation programs are other examples of our effort.

Military health care personnel have been, and will continue to be, increasingly involved in health promotion issues. Our eligible beneficiaries rely on health care professionals for information and guidance, and the health care system has been creative in designing mechanisms to meet the demand.

Adding preventive services to federal health insurance benefits should also be considered. The recent CHAMPUS Reform Initiative (CRI) provides an excellent model. Within CRI, managed care plans offer preventive services. For example, the enhanced benefits provided by the CHAMPUS prime program, which is similar to a health maintenance organization (HMO), include periodic physical examinations, well child care for children beyond 2 years of age, wellness classes, discounts for special local services, and routine pap smears. In addition, the federal sector should examine the issue of linking its health insurance costs to lifestyle risks. Incorporating incentives in the federal health insurance programs to reduce behavioral health risks would be cost effective in the long term.

3. Would there be value in an annual, national "check-up" to show the status of the proposed Year 2000 Objectives for the Nation?

Most certainly an evaluation component is essential, although the need for an annual evaluation could be questioned. A periodic Department of Defense worldwide survey, begun in 1980, provides an evaluation of the alcohol, drug and tobacco use trends of our personnel. In 1988, other lifestyle health behaviors were added to the survey. This survey does not apply to family members or civilian employees. The DoD survey has been conducted every two and a half years and we are satisfied that this is an appropriate interval for measuring change that results from our policy and programs. Currently there are no plans to conduct an annual survey. The current national surveys such as National Health Interview Survey do not identify military medical beneficiaries or Department of Defense civilian employees as a separate group. Consequently, at present we do not have a mechanism to evaluate the health risk behaviors of our military families or civilian employees.

It would be useful if these groups could be culled out of the existing survey sample.

4. Are there additional resources (people, technology or appropriations) that are necessary to adequately monitor and reach the proposed Year 2000 Objectives?

We believe that we have the resources to reach the proposed objectives. A review by the General Accounting Office, directed by the House Armed Services Committee, will focus on assessing the commitment of the Department to health promotion and primary prevention of disease. I believe a more definitive answer to your fourth question can be provided at the completion of this audit.

Mr. Chairman, this concludes my brief statement. I would be happy to answer any questions you may have.

UNITED STATES DEPARTMENT OF AGRICULTURE
HUMAN NUTRITION INFORMATION SERVICE

Statement of James T. Heimbach, Ph.D.
Acting Administrator
before the
Senate Subcommittee on Government Information and Regulation
March 20, 1990

Mr. Chairman and Members of the Committee:

I am James Heimbach, Acting Administrator of the Human Nutrition Information Service (HNIS). I am pleased to be here today to discuss the Department of Agriculture's role in the Year 2000 Health Objectives for the Nation being developed under the Public Health Service of the Department of Health and Human Services (DHHS). USDA has participated in the development and review of the nutrition objectives, one of the twenty-one national health priority areas being addressed in the Year 2000 Health Objectives. DHHS invited the Department of Agriculture to participate in the Work Group for nutrition, and the Human Nutrition Information Service represents USDA on this Group. My remarks today will address USDA's contribution to the development of realistic nutrition objectives for the Year 2000 and USDA's resources that can be used to monitor progress toward those objectives.

It should be mentioned that in addition to USDA participation on the Nutrition Work Group, the Agricultural Research Service (ARS) was requested by the House Appropriations Committee for Rural Development, Agriculture, and Related Agencies to review and report on the development of the nutrition objectives, prior to the fiscal year 1990 appropriations hearings, using its five Human Nutrition Research Centers. A report was prepared by an ad hoc ARS Task Group containing a member from each USDA Human Nutrition Research Center and submitted to Congress in early March 1989 entitled "Process and Progress in Development of the Year 2000 Health Objectives Relating to Nutrition." A copy of that report is being submitted along with my written testimony. The report reviewed draft materials available as of March 1, 1989, and indicated that further comments on the draft objectives would also be submitted to the co-leaders of the Work Group on Nutrition Objectives for their consideration. As the objectives have been developed and revised, comments have been submitted by the ARS Task Group.

The Nutrition Work Group was convened in the summer of 1988 to draft the nutrition objectives, review public comments and incorporate them to the extent possible, and provide continual review of the objectives as they are finalized.

The overall process being used by the Public Health Service in the development of the objectives and their review has been an open process giving opportunity for involvement by interested parties. Extensive public input has been sought through public hearings, non-Federal expert panel review of the draft objectives, and broad dissemination of the draft objectives for public comment.

In participating in the development of the nutrition objectives, USDA has emphasized two areas:

- One is the need for the objectives to build on current programs being delivered by the Federal Government. We believe coordination between the nutrition objectives and the goals of Federal nutrition programs, whether those programs are research, education, food assistance, or disease prevention, will strengthen the benefits to be realized by the public--that is improved health status. USDA's Food and Nutrition Policy states that "It is the policy of USDA to promote optimal human health and well-being through improved nutrition." (Departmental Regulation 1020-4, January 2, 1987). This statement emphasizes the importance of coordination of the Department's human nutrition-related activities with other governmental agencies and also with the agricultural food industry and public or private institutions.

- We have also concentrated on assuring that all objectives and advice given to the public have a strong, well-documented research base and be scientifically sound. This is essential for recommendations on the amounts of foods to consume as well as for recommendations on the amounts of nutrients to consume. Both of these areas of emphasis have been guiding factors in the deliberations of the Work Group. As a result, the nutrition objectives are in concert with the Dietary Guidelines for Americans and dietary guidance provided by USDA.

"The Dietary Guidelines for Americans," issued jointly by USDA and DHHS in 1980 and 1985, are a statement of Federal nutrition policy. This means that the concepts expressed in these Guidelines are "the basis of the food and nutrition education activities carried out by USDA and DHHS" (Memorandum of Understanding, USDA and DHHS, January 18, 1984). These Guidelines are the best advice from the Federal government for a nutritious, healthful diet. The "Surgeon General's Report on Nutrition and Health," released in 1988, "provides a comprehensive review of the most important scientific evidence in support of current Federal nutrition policy as stated in the Dietary Guidelines for Americans." (DHHS, 1988). The Year 2000 nutrition objectives are supportive of the concepts and principles emphasized in the Dietary Guidelines for Americans. There are objectives that address the prevalence of overweight, and the intake of fat, saturated fatty acids, sodium, complex carbohydrates, and alcohol, all issues addressed in the Dietary Guidelines.

The Human Nutrition Information Service and the Office of Disease Prevention and Health Promotion of DHHS have jointly sponsored the Dietary Guidelines Advisory Committee--a nine member panel of prominent physicians and nutritionists who have been working since January 1989 to review the 1985 edition of the Dietary Guidelines for Americans. Based on the Committee's Report, which is expected to be submitted to the Secretaries of USDA and DHHS in the next several weeks, USDA and DHHS will issue a revised edition of the Dietary Guidelines for Americans by the end of the year. Year 2000 nutrition objectives that touch on issues addressed in the Dietary Guidelines have been reviewed by the USDA and DHHS Executive Secretaries to the Dietary Guidelines Advisory Committee for comparability.

The primary focus of HNIS nutrition education research program is the development of research-based nutrition education materials for consumers to assist them in implementing the Dietary Guidelines for Americans. These materials will also assist Americans in reaching the targets set by the Year 2000 nutrition objectives.

USDA's Food Guide, developed in the early 1980's specifically to help people implement the Dietary Guidelines, specifies a recommended number of daily servings of major food groups. The Year 2000 nutrition objectives to increase intake of food sources of calcium, complex carbohydrates and fiber set goals for the population to attain daily servings of food groups that are the same as those in USDA's Food Guide. The objectives for the Year 2000 call for increasing the number of daily servings for dairy products (3 or more servings for 12-24 year olds and pregnant and lactating women and 2 servings for 25 year olds and over of foods rich in calcium, specifically dairy products), fruits and vegetables (5 or more servings), and grain products and legumes (6 or more servings). As I stated at the beginning, USDA has emphasized the importance of a strong, well-documented research base for all recommendations. The research base for USDA's Food Guide, including the recommendations for dairy products, fruits and vegetables, has been published in an Administrative Report (USDA, Adm. Report No. 377, 1984) and in a scientific journal (J. Nutr. Ed. 19, 1987).

Over the past year, HNIS has released four new colorful booklets on (1) Preparing Food and Planning Menus, (2) Making

Bag Lunches, Snacks, and Desserts, (3) Shopping for Food and Making Meals in Minutes, and (4) Eating Better When Eating Out. The booklets emphasize the USDA Food Guide and other practical how-to information that consumers need to put the Dietary Guidelines for Americans into practice in their daily food choices. A new consumer nutrition education campaign entitled "Eating Right...The Dietary Guidelines Way" was launched last July with the release of the booklets. The ongoing campaign is designed to increase awareness of the Dietary Guidelines for Americans and to help people put the Dietary Guidelines into action in their lives. Outreach is targeted to the public through the media and other information multipliers including health and nutrition professionals in the public and private sectors who interact with the public. These efforts, and ones like them in the future, will play a major role in helping the nation to reach the Year 2000 nutrition objectives by the end of the century.

In some cases, the objectives call for particular emphasis on special groups. We are also working on production of dietary guidance materials that focus on the needs of special groups. A cooperative effort is underway with the University of Nebraska to adopt current dietary guidance materials for use with low-literacy audiences. Another cooperative project is underway with the National Institute on Aging to develop materials to help healthy older Americans implement the Dietary Guidelines. And another cooperative project is underway with the Association for the Advancement of Health Education to reach teens through the high school health education curriculum.

There are objectives on reducing the prevalence of overweight and following sound dietary practices to achieve weight reduction. The Human Nutrition Information Service will soon be releasing a revised edition of a popular pocket guide entitled "Calories and Your Weight." This publication provides guidance for healthful eating patterns and food selections to achieve weight loss as well listing the calorie content of about 400 frequently consumed foods in common serving sizes.

There are a wide range of programs in USDA beyond the Human Nutrition Information Service that contribute significantly to meeting the goals of the Year 2000 nutrition objectives. Let me briefly highlight two areas. Federal food assistance programs administered by the Food and Nutrition Service provide access to a more nutritious diet for persons with low-incomes and encourage nutritious eating patterns among the Nation's children. Specifically, the Supplemental Food Program for Women, Infants, and Children--the WIC Program--is targeted at low-income mothers and young children who are at nutritional risk. The Year 2000 objectives addressing iron deficiency, impaired growth, and breastfeeding are in concert with the goals of the WIC Program. This program provides participants with selected foods that are good sources of problem nutrients, including iron, and with nutrition education. It helps get low-income pregnant women under medical supervision where problems--including those related to nutritional status--can be identified and treated. The WIC Program encourages breastfeeding and counsels mothers on its nutrition advantages.

The programs of the Extension Service and Cooperative Extension System provide education and outreach in every county in the nation. Improving health and nutrition have been identified as one of the priority program goals of the Extension Service. How the goals are carried out varies from county to county depending on the needs of the audience served. Of particular note is Extension's Expanded Food and Nutrition Education Program which targets low-income families, teaching them principles of nutrition and how to use limited food resources to improve family diets.

I would now like to turn my remarks back to the Human Nutrition Information Service and discuss nutrition monitoring and surveillance. The components of the National Nutrition Monitoring System will serve as the primary mechanism to monitor progress in meeting the Year 2000 nutrition objectives. The NNMS is a system of activities, primarily in USDA and DHHS, that provide timely information about the dietary and nutritional status of Americans and the factors that affect that status. Two reports on the dietary and nutritional status of the population based on data from the monitoring system have been submitted to Congress. The second report, "Nutrition Monitoring in the United States: An Update Report on Nutrition Monitoring" was published in September 1989. The report includes an update on the dietary and nutritional status of the U.S. population since the first report released in 1986 and an indepth integrative analysis of two specific topics--nutrition factors in cardiovascular disease and assessment of iron nutriture. Both topics are addressed in the Year 2000 nutrition objectives.

The Human Nutrition Information Service is responsible for one of the two major components of the National Nutrition Monitoring System--the system of Nationwide Food Consumption Surveys (NFCS) which includes the Continuing Survey of Food Intakes by Individuals (CSFII). The Nationwide Food Consumption Survey is a decennial nationwide survey that provides data on 3-day food and nutrient intakes of individuals and information on the foods used by households during a seven-day period and the cost of those foods. It was last conducted in 1987-88 and will be conducted again in 1997-98. The Continuing Survey has been designed to assess a nationally representative sample of the population on a continuous basis. This survey provides the ability to track and forecast the dietary status of the U.S. population. It was first initiated in 1985 and 1986. In each of those years, a national sample of women 19-50 years and their 1-5 year old children were surveyed because results from previous surveys had shown that they were more likely than other groups to have nutrient intakes below recommended levels. A national sample of men 19-50 years old was included in 1985. Results from the 1985 and 1986 Continuing Survey have been used as the source of baseline data for a number of the Year 2000 nutrition objectives.

In 1989, the Continuing Survey was reinstated to be conducted every year. The survey was redesigned to collect food and nutrient intakes for all sex/age groups and to report results using a moving average approach. This approach is a cost-effective means of providing trend information in a timely manner. It was recommended by two committees of the National

Academy of Sciences. Plans call for the publication of Continuing Survey results for men and women age 20 to 49 after 2 years, and other sex/age groups after 3 to 5 years of data collection.

Both the decennial and the Continuing Survey include separate low-income samples. These samples, comprising households with incomes at or below 130 percent of poverty, are of particular value for tracking progress of the low-income population toward achieving the Year 2000 nutrition objectives.

The Continuing Survey has also been designed to accommodate modules from other agencies with concerns relative to nutrition monitoring. One example is a cooperative effort between our agency and USDA's Food Safety and Inspection Service, and DHHS's Food and Drug Administration (FDA) to establish a new component of the Continuing Survey, the Diet/Health Knowledge Survey, to assess consumer knowledge and attitudes on diet/health issues. The Diet/Health Knowledge Survey represents, for the first time, a nationwide sample being used to study the relationship between individuals' actual dietary intakes and their knowledge and attitudes about dietary behavior. We believe that this capability to add modules to the Continuing Survey at any given year provides new opportunities to conduct special smaller studies to address progress toward selected Year 2000 nutrition objectives and other important issues.

The combination of all the parts of USDA's system of Nationwide Food Consumption Surveys will offer a wealth of data to assess how the country is doing in meeting the Year 2000 nutrition objectives over the next decade. The decennial survey provides data from sufficiently large groups to study differences among population segments with regard to socioeconomic factors associated with food consumption and expenditure patterns. The smaller surveys provide data to monitor trends in food and nutrient intakes by the general and low-income populations. The Nationwide Food Consumption Survey, the Continuing Survey, and the Diet/Health Knowledge Survey provide data that can be used to monitor and assess progress toward many of the nutrition objectives. Some specific examples include:

- self-reported height and weight data to determine prevalence of overweight

- nutrient intake data of the population and subgroups to assess the intakes of specific nutrients that have been targeted, including dietary fat, saturated fatty acid, and calcium

- food intake data of the population and subgroups to assess consumption of specific food groups that have been targeted, including fruits, vegetables, dairy products, and grain products, and to examine food consumption patterns and dietary practices of the population and population subgroups

- food purchasing and preparation techniques to assess use of foods with reduced salt and sodium, use of salt in food preparation, and use of salt at the table

- use of food labels in making food selections

In summary, I would like to say that the Year 2000 nutrition objectives as drafted provide good coverage of the major nutrition issues in this country. Careful attention has been given to defining objectives that enhance and build upon the goals of existing Federal programs, specifically those which are designed to address the nutrition problems targeted in the objectives. Many of the goals are ambitious and will be a challenge. It will take the combined efforts at the Federal, State, and local level, including health professionals as well as the business and industry community, to meet this challenge. The nutrition education programs of USDA that focus on the Dietary Guidelines for Americans will play an important role in meeting this challenge. The nutrition monitoring activities of the Human Nutrition Information Service, including the Nationwide Food Consumption Survey and the yearly Continuing Survey of Food Intakes by Individuals, will provide timely dietary data to assess how the country is doing in meeting the objectives over the next decade.

This concludes my remarks. I will be happy to answer any questions.

ATTACHMENT

PROCESS AND PROGRESS IN DEVELOPMENT OF THE YEAR 2000 HEALTH OBJECTIVES RELATING TO NUTRITION

A Report to Congress

March 1989

PROCESS AND PROGRESS IN DEVELOPMENT OF THE YEAR 2000 HEALTH OBJECTIVES RELATING TO NUTRITION

A Report to Congress

I. Charge

The House Appropriations Committee Report concerning the 1989 appropriation to the Agricultural Research Service (ARS) contained the following:

> "Human Nutrition Research—Since the Department, through the Human Nutrition Information Service, is the Federal governments lead agency on nutrition matters, the Committee will expect the Department using its human nutrition research centers, to prepare a report prior to the fiscal year 1990 appropriation hearings regarding work done thus far with respect to nutrition matters in the Year 2000 Health Objectives study conducted by the Department of Health and Human Services. The centers should review the testimony and material presented at the various public hearings regarding this study for comparison with current verifiable scientific conclusions on human nutrition. The centers should also review the methodology of preparing the final report along with the data supporting the report's recommendations."

Accordingly, this report is hereby submitted.

II. Procedure

In order to carry out this mandate, an ad hoc ARS Task Group was formed, composed of members from each of the five ARS Human Nutrition Research Centers (named by the Center Director) and the Assistant to the Deputy Administrator for Human Nutrition of ARS. The scientists named to the ARS task group were: Jeffrey Blumberg, Human Nutrition Research Center on Aging (HNRCA); Helene Guttman, Beltsville Human Nutrition Research Cetner (BHNRC); Leslie Klevay, Grand Forks Human Nutrition Research Center (GFHNRC); Corinne Montandon, Childrens' Nutrition Research Center (CNRC); Judith Turnlund, Western Human Nutrition Research Center (WHNRC); and Gerald Combs, National Program Staff, ARS.

Information was obtained from James Heimbach, Administrator, Human Nutrition Information Service (HNIS) and USDA liaison member to the PHS Work Group for Year 2000 Nutrition Objectives; Darla Danford, Division of Nutrition Research Coordination (DNRC), National Institutes of Health (NIH), and cochairperson of the PHS Work Group for Year 2000 Nutrition Objectives; and Michael Stoto, Institute of Medicine (IOM), National Academy of Sciences (NAS), and reviewed prior to or at a meeting held in Washington, D.C. on February 1, 1989.

The preparation of the Year 2000 Health Objectives in all twenty-one priority areas, including "Improve Nutrition" were in draft stages of preparation and will not be available even to the PHS Steering Group on the Year 2000 Health Objectives, chaired by James Harrell, until April 1. The emphasis of this report, therefore, is on the process by which the Year 2000 Health Objectives are being developed. The draft components, thus far, prepared by the members of the Work Group for Year 2000 Nutrition Objectives have been reviewed and comments are being provided to the cochairpersons for their consideration as these objectives are finalized.

III. The Process of Developing Year 2000 Nutrition Objectives

The *ad hoc* ARS Task Group on the Year 2000 Health Objectives first wishes to commend the U.S. Public Health Service for the approach used in the development of the year 2000 Health Objectives. The approach was designed by the Office of Disease Prevention and Health Promotion (ODPHP) in the Office of the Assistant Secretary for Health (OASH) to be an open process and to involve a broad range of professionals, individuals, organizations and Federal agencies with much greater opportunities for review than occurred in the development of the 1990 Health Objectives. This greater involvement of individuals and organizations will help importantly in the actual implementation of programs to attain these objectives. The process used to develop the Year 2000 Health Objectives is as follows:

Role of I.O.M.

The national response to the 1990 Health Objectives confirmed the usefulness of the Objective approach. A group of State health officers had some very specific recommendations. They felt that the Objectives should be National, and that Federal, State, and local governmental officials, industry, educational institutions, and private non-profit organizations must "take ownership" of the Objectives and play a role in their implementation.

Accordingly, DHHS let a contract with the Institute of Medicine (IOM) of the National Academy of Sciences to form a consortium of over 200 National professional and voluntary organizations and to jointly conduct public hearings in seven cities on the Year 2000 Health Objectives. These public hearings were held by the IOM and PHS from January through March, 1988, in Birmingham, Alabama; Denver, Colorado; Detroit, Michigan; Houston, Texas; Los Angeles, California; New York, New York; and Seattle, Washington. These hearings were intended to provide a broad spectrum of information about the special health care needs of local, racial, ethnic, and other special population groups in the United States. In all, over 770 individuals and organizations submitted testimony. Using this information, work groups were formed by the Public Health Service to produce draft Objectives for each of 21 priority health areas, one of which is "Improve Nutrition."

The individuals who testified were asked to supplement their remarks with written material and documentation. The written testimony was forwarded by IOM to the respective health area Work Group. Approximately a third of the speakers dealt with the need for preventive services targeted against specific diseases such as cancer, heart disease, stroke, infant mortality, unintended pregnancies and other chronic conditions. More than a fourth stressed health promotion issues, including behavior modification and education. Strengthened programs were requested for dealing with smoking, alcohol, drug abuse, nutrition and fitness. Others (about 1 in 5) testified about health problems and solutions associated with physical and social environment. These hearings have been summarized by IOM for use by the various Work Groups.

Work Group for Year 2000 Nutrition Objectives

In August 1988, DHHS announced the lead agencies for each of the 21 Work Groups for the Year 2000 Health Objectives. The co-lead agency coordinators named for the Nutrition Objectives were Allan Forbes, Food and Drug Administration, and Darla Danford, The National Institutes of Health. Agency members of the Work Group for the Year 2000 Nutrition Objectives included Frederick Trowbridge, Center for Disease Control; Ann Prendergast, Health Resources and Services Administration; M. Yvonne Jackson, Indian Health Services; Catherine Wotecki, National Center for Health Statistics; and Linda Meyers, ODPHP/OASH. Liaison agency representatives included Kay Loughrey, American Public Health Association; Nancy Zimmerman, Association of State and Territorial Public Health Nutrition Program Directors; James Heimbach, Department of Agriculture, and Antoinette Hagey, Department of Defense.

A Public Health Service Steering Committee with representatives from DHHS also was established to guide the process.

Drafting the Nutrition Objectives

The Nutrition Objectives Work Group has held seven monthly meetings, reviewing material from the IOM sponsored hearings becoming familiar with the guidelines and drafting Year 2000 Nutrition Objectives.

In December, draft Nutrition Objectives were submitted to the Life Sciences Research Office (LSRO), Federation of American Societies for Experimental Biology for review by an outside Expert Panel.

Review by Expert Panel

The Expert Panel on National Nutrition Objectives for the Year 2000, convened by LSRO, was composed of the following members: John A Colwell, M.D., Ph.D., Medical University of South Carolina; Cuthberto Garza, M.D., Ph.D., Cornell University; Robert P. Heaney, M.D., Creighton University; David Kritchevsky, Ph.D., Wistar Institute; Sheryl Lee, M.P.H., R.D., Arizona Department of Health Services; Albert I. Mendeloff, M.D., M.P.H., Johns Hopkins University School of Medicine; F. Xavier Pi-Sunyer, M.D., M.P.H., St. Luke's Roosevelt Hospital; Maurice E. Shils, M.D., Sc.D., Winston-Salem, North Carolina; Elwood W. Speckmann, Ph.D., National Dairy Council.

The comments from the LSRO convened Expert Panel are not yet available, but are expected to be available to the Work Group by March 1, 1989.

Final Revised Draft Nutrition Objectives

The draft Nutrition Objectives also have been sent to a number of professional specialists by the Work Group for comments. Copies have been provided to the AHS *ad hoc* Task Group on the Year 2000 Health Objectives for their review and comments. Comments will be sent directly to the Nutrition Objectives Work Group.

The Nutrition Objectives Work Group will complete the final draft, having received the various comments from the different reviewers, by April 1, 1989, at which time the finalized draft will be forwarded to the Deputy Assistant Secretary for Health, ODPHP.

Cross-Cutting Areas Involving Nutrition

A number of other Work Groups, other than "Improve Nutrition" include nutrition related objectives. These Work Groups include the following:

2 Reduce Alcohol and Other Drug Abuse

4 Increase Physical Activity and Fitness

13 Improve Maternal and Infant Health

14 Improve Oral Health

15 Reduce Adolescent Pregnancy and Improve Reproductive Health

16 Prevent, Detect, and Control High Blood Cholesterol and High Blood Pressure

17 Prevent, Detect, and Control Cancer

18 Prevent, Detect, and Control Other Chronic Diseases and Disorders

19 Maintain the Health and Quality of Life of Older People

20 Improve Health Education and Access to Preventive Health Services

It is our understanding that the final draft Objectives for each Work Group will be cross indexed in such a way to ensure consistency throughout.

Draft Objectives to be Published in Federal Register

It is planned that on June 1, 1989, draft Objectives for the Year 2000 will be published in the Federal Register for public comments. Following review of public comments, completed Objectives are expected to be published by July, 1990, as the Surgeon General's Second Report on Disease Prevention and Health Promotion.

IV. Summary

The ARS ad hoc Task Group on Year 2000 Health Objectives has reviewed available draft Objectives and other information resulting from the seven regional hearings held by the IOM and DHHS on Year 2000 Health Objectives. The ARS Task Group commends the Public Health Service for the broad range of input from local, State and Federal agencies, professional and non-profit organizations and individuals concerning the various health needs of various population groups, as a means of identifying appropriate nutrition objectives. The ARS Task Group has reviewed the IOM report and the present draft report of the Work Group on Year 2000 Nutrition Objectives. It is planned to again review the proposed final draft when it becomes available on April 1. Any comments the ARS Task Group may have will be sent to the co-leaders of the Work Group on Nutrition Objectives for their consideration.

Question relating to Tobacco from Senator Bingaman to Dr. Heimbach

Question: How involved in anti-smoking efforts is USDA? Is the growing of tobacco encouraged or supported in any way? If yes, what is the extent of that support? Is this support inconsistent with the anti-smoking objectives?

Answer: The Agricultural Adjustment Act of 1938, as amended (1938 Act), and the Agricultural Act of 1949, as amended (1949 Act), provide for production adjustment and price support programs for tobacco. There are no direct Government subsidies to the tobacco industry. Rather, price support loans are made to producer-owned cooperative associations in order that the associations may pay advances to growers for tobacco that does not sell for at least the price support rate which is established in accordance with the 1949 Act.

The 1949 Act requires tobacco producers to contribute to an account or fund to ensure the operation of the tobacco price support program at no net cost to the taxpayer, except for the administrative expense common to all commodity programs. Also, producer bear the cost of grading the inspection services previously paid by the Federal Government.

The Consolidated Omnibus Budget Reconciliation Act of 1985 provided for a number of needed changes to the 1938 and the 1949 Acts with respect to the tobacco program. These changes have improved program operations through more market-oriented price support levels and marketing quotas, thereby reducing the quantity of tobacco pledged as loan collateral. Moreover, as long as there is a market for tobacco, American farms have a right to supply that market in competition with foreign producers; and as long as statutes mandate a tobacco price support program, the Department of Agriculture is required to carry out that program in an equitable and cost-effective manner.

Termination of the U.S. tobacco program would not end the use of tobacco product. Economic analyses indicate that deregulation of U.S. tobacco production would mean a substantial expansion of production. Unless use of foreign-produced tobacco was made illegal, off-shore tobacco would continue to be available to manufacturers.

Mr. Bingaman: Is USDA adequately studying environmental factors (global warming, ozone depletion, pollution) and their effects on all phases of the food supply? Are environmental factors adequately addressed in the Year 2000 Objectives?

Dr. Helmback: USDA, under the coordination of the Special Assistant for Global Change Issues, in the Office of the Assistant Secretary for Science and Education, is developing a Strategic Plan for Global Change, Research, Education and Technology Transfer. This long term strategy will define objectives for the next decade to limit or mitigate the effects of agriculture and forestry on the atmosphere and environment, and to adapt to potential changes in the environment associated with possible long-term global changes. All sectors of agriculture and forestry are included; goods and services, food and fiber production, processing, storage, transportation and marketing. Issues associated with potential changes in the climate, quantity and effect of increased ultra-violet radiation and tropospheric effects of hydrocarbons, oxides of nitrogen and sulphur and increased low level ozone are part of various programs under development over the next decade.

STATEMENT OF

DR. JANE A. McDONALD
ASSOCIATE PROFESSOR OF EDUCATIONAL LEADERSHIP
GEORGE WASHINGTON UNIVERSITY
WASHINGTON, D.C.
AND
PROJECT MANAGER
"HEALTHY KIDS FOR THE YEAR 2000"
AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS
ARLINGTON, VIRGINIA

ON

THE PUBLIC HEALTH SERVICE'S
NATIONAL HEALTH OBJECTIVES FOR THE YEAR 2000

GIVEN ON BEHALF OF

THE AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS

BEFORE THE

GOVERNMENTAL AFFAIRS SUBCOMMITTEE ON
GOVERNMENT INFORMATION AND REGULATION

MARCH 20, 1990

Chairman Bingaman and distinguished members of the Subcommittee: Thank you for the opportunity to appear before the Senate Subcommittee on Government Information and Regulation and to speak about issues relevant to the quality of U.S. health promotion information concerning the Nation's Health Objectives for the Year 2000. My name is Jane McDonald. I am a professor of Educational Leadership at George Washington University and the project manager of a grant awarded to the American Association of School Administrators by the Department of Health and Human Services to promote awareness of the Year 2,000 Health Objectives in our nation's public schools. My remarks are on behalf of nearly 19,000 members of the American Association of School Administrators who lead thousands of educators in elementary and secondary schools in approximately 16,000 school districts across the country.

My testimony is organized around the four questions outlined in the Chairman's letter concerning the Public Health Service's National Health Objectives for the Year 2000. I included an additional question to which I will respond with information and opinions expressed by school superintendents who have exemplary health education programs in their districts. These questions include:

1. Are the objectives valid, realistic, and attainable?
2. What would be required for the federal government to encourage the attainment of the objectives that apply to educational institutions?
3. Would there be value in an annual, national "check-up" to show the status of the objectives?
4. Are there additional resources that are necessary to adequately monitor and reach the objectives?
5. What suggestions do school superintendents with exemplary health education programs have for promoting and implementing effective health education programs in school districts?

1. Are the objectives valid, realistic, and attainable?

Yes, the national health objectives seem to be realistic and attainable. I cannot comment on their validity since I do not know personally if the assumptions behind the objectives are valid. I can make general comments about the objectives, however.

In general, the objectives appear to be written to mobilize health professionals and health advocacy groups and are not expressed in language and content for the general public. The objectives are too numerous and too detailed in content. Many lack information on how a person can reach the stated outcome, and many are not stringent enough for a ten year time frame. All objectives are equally weighted so those objectives that have greater importance or impact for change do not stand out from the others. Only a few objectives call for health education training of community members, parents, and teachers; yet education is the key for helping people make informed, healthy choices in their lives. Health problems of the homeless need to be addressed. Objectives to create a national health care program or local employee assistance programs are missing from the list altogether. Also missing is a stated objective for the collaboration of efforts among various service agencies.

One of the most important objectives, # 20.14 which refers to providing K-12 comprehensive school health education programs, needs to be highlighted as a major objective and stated more ambitiously. The expectation needs to be that 100 percent of the school districts obtaining this objective by the year 2000, not just 50 percent as stated. It is especially important for children and young people to develop early the mental and physical attitudes, skills, and habits for living healthy lives.

2. What would be required for the federal government to encourage the attainment of the objectives that apply to educational institutions?

There are three major ways in which the federal government can help:

a. Funding. If the health of our nation is a priority and if schools are expected to play a major role in carrying our this objective, then adequate funding must accompany the requests and mandates. Health programs usually take a back seat to other programs in school districts. Categorical grants have helped but tend to fragment the total comprehensive health education program by emphasizing only one area of need. Categorical aid still is necessary and appreciated. In some districts the only health education afforded children is obtained through this grant in aid. Yet, funding that allows for flexibility of use and is available on a continual basis (like Chapter I) is needed. With "flexible use" funding, school districts that currently do not have a comprehensive health education program could create and maintain one. School districts who already have extensive programs could use the funds to expand and adjust their health programs to meet the changing needs identified in each community.

   Additionally, monies made available to help fund the training of certified health educators would be beneficial. Currently, there are only about 1,500 c.h.e. in the country and 16,000 school districts. Funding is also necessary for counseling and other mental health services for students of all ages and their families.

b. Legislation. The federal government must continue to tackle and strengthen legislation on alcohol advertising, hand guns and automatic rifles, public smoking, food additives, pesticide control, and other environmental problems. A national health program and incentives for employee assistance programs are other areas of concern to schools.

Alcohol is the number one health problem in schools across the nation. Alcohol-related traffic crashes are the leading cause of death and spinal cord injury for young Americans. Although attitudes about drinking and driving are beginning to change slowly among young people, the attitude about drinking has not. "Getting wasted" is an accepted practice and subject of conversation among our too many of our youth. The advertisement on television of beer, wine, and wine coolers is linked to sex, fun, sports, friends, and a life-style that "couldn't get any better." Children and young adults are greatly influenced by the media. Congress must act to legislate the removal of all alcoholic products from the media. This one act alone would have a major impact on the health and life span of our youth and nation.

c. Publicity. Once the national health goals and objectives are finalized, the general public needs to know what the objectives are and what each person needs to do to meet the objectives. A "Madison Avenue" approach to publicizing the objectives is needed to attract and hold the attention of various age groups. On-going reports; national recognition for states, communities, and schools who have exemplary health programs or make outstanding progress in meeting the objectives; and televised health specials can be incorporated into a planned and continuous publicity program to improve the quality of life for our citizens over the next ten years.

3. Would there be value in an annual, national "check-up" to show the status of the objectives?

Yes, there is value in having an annual "check-up." At the least, such an effort will bring national recognition and attention to health issues. Some of the questions to consider in planning this task are (1) What is the purpose of the "check-up", (2) What data will be collected, (3) How will the data be collected and by whom, (4) How will the results be used, (5) What follow-up will take place, (6) How will this effort make a difference in changing the quality of life for Americans, and (7) Will funds be available if follow-up action is needed?

Personally, I believe the data needs to reflect national, state, and local community results. People need to be involved and impacted at the level which is closest to them, so results only at the national level are too far removed from the general public.

4. Are there additional resources that are necessary to adequately monitor and reach the objectives? (people, technology, appropriations)

My response to this question is reflected in question #2. My recommendation to the Subcommittee is to establish focus groups across the country to address this question. The Subcommittee might ask students, teachers, curriculum specialists, certified health educators, and other appropriate individuals to participate.

5. What suggestions do school superintendents with exemplary health education programs have for promoting and implementing effective health education programs in school districts?

Superintendents with exemplary health education programs make the following suggestions:

a. Confront and examine competing value systems with legislators and local community members
b. Since alcohol is the number one health issue in schools, speak out against alcohol advertising in the media and similar exploitation of our youth
c. Inform politicians of health issues in schools
d. Influence teacher preparation programs at universities and colleges to include training in and emphasis on health education and developing healthy lifestyles
e. Establish partnerships with other agencies and organizations to work for the "total child"
f. Devise a plan for dealing with vested interest groups
g. Obtain health funding that allows for flexible use in school health programs
h. Form coalitions to plan and implement comprehensive health education programs
i. Conduct on-going staff development activities in health education for teachers, administrators, and support workers
j. Develop a strong parent component in training and implementing health objectives
k. Ensure that the leadership of a district is supportive of health education and that a specific person is designated within the school system to coordinate health efforts throughout the district
l. Make healthy minds and bodies a continuous, long-term commitment and priority of the district
m. Get the teaching and administrative staff to personally "buy in" to the importance of a comprehensive health education program and of educators as role models for children of all ages
n. Use the school as a base for neighborhood action
o. Generously give rewards and recognition for exemplary health practices

within the district

p. Be accountable. Commit to evaluating, monitoring, and adjusting health programs to reach stated goals and objectives
q. Encourage and reward risk taking and innovation in program design, implementation, and evaluation (What does not work can be valuable too.)
r. Develop objectives and criteria for evaluation before the program is implemented
s. Include crisis, prevention, intervention, and follow-up components in a comprehensive health education program
t. Communicate often the health vision of the district to those individuals inside the school system and in the community.

Conclusion

Lifestyle is now recognized as a major determinant of health. We all need basic knowledge, skills, and attitudes if we are to make wise decisions about health. But it is especially important to teach children and young adults about the subject. Comprehensive health education programs in school districts can provide the most appropriate, systematic, and efficient means available to enable young people to develop healthy habits and avoid health risks.

Schools cannot do the job alone. Collaboration of agencies, appropriate funding, proper legislative action, and publicity are vital components to quality promotion and attainment of the Nation's Health Objectives for the Year 2000.

Again, thank you for this opportunity. I will be happy to answer any questions you may have.

**Governmental Affairs Subcommittee on
Government Information and Regulation
March 20, 1990**

Testimony on the National Objectives for the Year 2000 and the Model Standards for Community Preventive Health Services

**by Charlie Stokes, representing
the Association of State and Territorial Health Officials**

I am Charlie Stokes, Interim Director of the Missouri Department of Health; and member of the Executive Committee of the Association of State and Territorial Health Officials (ASTHO). I am here today to provide information concerning data for the Year 2000 Health Objectives for the Nation. These objectives and the guidance provided in the companion volume, Model Standards for Community Preventive Health Services, will provide focus for public health programs for the next 10 years and expand our baselines for measuring progress in promoting health and preventing disease.

These two documents build on a tradition begun in the late 70's to objectify health outcomes so progress against preventable illness and injury could be measured and sustained. Public health has just completed its efforts toward the 1990 Objectives for the Nation, the immediate predecessor of this project. We are now looking forward to the health challenges presented in '90s and intend to carry forward our commitment to the health of our citizens in renewed efforts toward achievement of the Year 2000 Objectives.

I would also like to inform you about a piece of legislation, the Health Objectives 2000 Act, which will allow the states to address these objectives in a much more systemmatic and comprehensive way.

First, I will respond to the questions posed by Senator Bingaman in his invitation to testify.

1. Are the objectives valid and measurable?

The intent of the project is that they are.

The purpose of the objectives is to provide a way of measuring progress in public health policy and programs. Organizers of the project have gone to a great deal of effort to solicit expert opinion from a wide range of professions and organizations in developing these objectives. There are currently 21 priority areas, each with a multidisciplinary workgroup which has solicited comments from a broader audience for their objectives. The entire document has been reviewed widely and the workgroups are currently revising their original drafts. When completed, the objectives should be a broadly critiqued consensus of the best information available at the present time.

In some areas, however, information is not as complete as we would like. Because resources are often not sufficient to allow for the development of tracking systems and data bases, we cannot always measure what we would like to be able to measure. The project is also identifying areas of inadequate information and has a specific workgroup assigned to identify and prioritize information needs so that these information resources can be developed during the next decade.

2. What is the relationship between these objectives and the Model Standards Project?

Both projects were undertaken about the same time and for similar reasons, but they are separate documents. Over the past decade as states and localities have attempted to integrate them into local planning activities, it became apparent that they were not entirely compatible.

The Institute of Medicine held hearings across the nation to solicit testimony in preparation for developing national year 2000 objectives. Many who testified had attempted to use both documents in state or local planning but found the two documents confusing when used together. The differences between the two documents, from overall structure to the wording of individual objective statements, were significant enough to make implementation very difficult. It was strongly urged that both documents be revised to be complementary.

Differences

IOM findings
"The Objectives for the Nation address the question of what it is we want to achieve; Model Standards is presented in a format which addresses how we are going to achieve those goals."

"The Objectives for the Nation are designed to reflect national goals. However, most national objectives can only be achieved if local communities work to accomplish them. Model Standards are an effective tool for assisting local communities to establish appropriate and attainable objectives."

Purpose

Purpose of 1990 objectives, from the introduction...
The Objectives "are intended to be national – not federal – objectives. To realize the potential for reducing the rates of premature death and disability to the levels set forth here requires a truly national commitment, including, but going far beyond, that of government."

Purpose of Model Standards, from Preface of 2nd Edition...
"This work provides comprehensive goals and objectives to help community leaders work together to improve health, the environment, and quality of life in their communities."

History

The Public Health Service initiated a process, beginning with the publication of *Healthy People* in 1979, that identified specific health status goals for each of five major life stages. These goals and their resulting objectives were published in the 1980 document, *Promoting Health/Preventing Disease: Objectives for the Nation.* These are commonly referred to as the 1990 objectives. These objectives were developed in the participation of over 500 individuals and organizations through conferences and peer review.

In 1977, Congress charged HEW with the responsibility of developing model standards for population-based prevention services delivered in communities. This project was undertaken jointly, with CDC funding, by the American Public Health Association, the National Association of County Health Officials, the Centers for Disease Control, The Association of State and Territorial Health Officials, and the United States Conference of Local Health Officials. A workgroup was formed with representatives from each of these organizations to undertake a similar developmental process as the 1990 objectives. In addition, the standards were field-tested in a variety of communities. Changes resulting from these evaluations of these field tests were incorporated in the final version.

Structurally, the Model Standards focused on program areas rather than health status goals. Objective statements were constructed in a "fill-in-the blank" format so that localities could insert their own data, and target dates.

With the formats constructed in different styles and for different audiences, the two documents were not completely compatible, even though they covered the same general territory. In revising these documents to focus on the year 2000, both workgroups have agreed to combine their separate documents into an integrated structure. The objectives and model standards will be published in two volumes of the Year 2000 Objectives for the Nation. Twenty-one priority areas have been selected. The Objectives workgroups will establish the national objectives; the Model Standards workgroup will expand the national objectives into a workbook that can be utilized for planning at the community level. This plan strengthens the utility of each document and provides a strong, clear focus for prevention policy for the next decade.

Timeline

(See timeline appended to testimony.)

3. Does the development of a nationwide plan and report have meaning on a state and local level?

Yes; it guides our own policy development and gives us a way of comparing our progress with other states.

Many states, including Missouri, responded to the 1990 Objectives by developing our own versions based on state level data. This provides us with the opportunity to compare progress, respond to innovations in other states and to assist the federal government in identifying health "hot spots" or those areas below the national level of achievement that may need more targeted interventions to bring them up to the national baseline.

At the local level, these documents can be used in the same way.

The Model Standards, in fact, are designed for use at the local level in community-based planning for health programs and services. With their fill-in-the-blank format, local communities can select and personalize those objectives that are most pertinent to their own situations. It functions much as a "cookbook" in that in provides information on just about anything that could conceivably be done within a community's health system. Again, the consistency of style in the way objectives are set up and worded allow for comparisons with other communities.

4. Would the national "check-up" be matched by state health departments?

Insofar as states are able to measure progress, the checkup would be matched by state health departments.

Most states have been responsive to the 1990 objectives. There is great anticipation among the states for the year 2000 objectives as well. Many state health departments have been involved with their development so far.

States do not always have state-level data to match national data.

Quality of state data varies depending on the amount of resources each state is able to put into data base development. Vital statistics and communicable disease data are available everywhere, but there is a wide disparity among states regarding the availability of cancer registries, head and spinal cord injury registries, birth defect registries, behavior risk factor surveys, hospital discharge data, environmental health effects and others.

The IOM report, *The Future of Public Health*, cited data development as one of the infrastructure issues that has been poorly supported over the years and that has significantly hampered states' ability to respond to health threats in the population.

The Health Objectives 2000 Act (S. 2056) is a proposal designed to confront these weaknesses by providing states with resources to strengthen the public health infrastructure and directly address the goals in the Year 2000 Objectives. Each state would receive a block grant to specifically implement their selection of year 2000 objectives. It requires each state to submit a plan and report progress toward the plan on an annual basis. This information would be compiled for Congress's information by HHS, thereby tracking national progress toward the objectives. These funds would not only cover program expenses, but also provide resources to develop the missing data bases and information sources needed to identify needs and track progress. Assessment data base development would not be classified as administrative costs for the purposes of the block grant, and therefore a state could spend what it needed to build the data collection systems it deemed necessary to track its objectives. In addition, a portion of HHS administrative costs would be reserved to provide technical assistance to states in developing theses data sets. See the attached fact sheet for information about the Health Objectives 2000 Act.

While many states addressed the 1990 objectives, their attempts were sporadic and inconsistent from one state to another specifically because of the variation of resources each state was able to devote to planning activities. The Health Objectives 2000 Act would be a significant boost to both the states and the nation in obtaining the information needed to make strategic decisions on the distribution of preventive health services – services that have the proven potential to offset some of the escalation in medical expeditures that threaten our entire health care system.

I have a concern over the level of authorization attached to the bill.

In its original version, the bill set aside $1 billion to be divided among the states for implementation of the Year 2000 Objectives. Since that time, the authorization level has been cut to $300 million and the entire public health block grant, currently funded at $89 million, has been folded into the total. Since programs are rarely funded at the full authorization level, the bill in its current form would not significantly improve the states' ability to repond effectively to national health objectives.

I would like to see the authorization level restored to the $1 billion level. In Missouri alone, we will be spending slightly over $1 billion in our Medicaid budget for fiscal year 1991. Missouri's portion under the $1 billion authorization level would be approximately $20 million. In contrast to the high costs of medical care, we are talking about a relatively small investment, that, if successful, can mean the curtailment of some of the illnesses and injury that lead to expensive treatment. It can also mean reaching a greater portion of the uninsured – in Missouri, estimated to be a quarter of our population – with preventive and primary care services to which they rarely have access. This investment is "penny-wise." Public health will give you a good return.

5. Conclusion

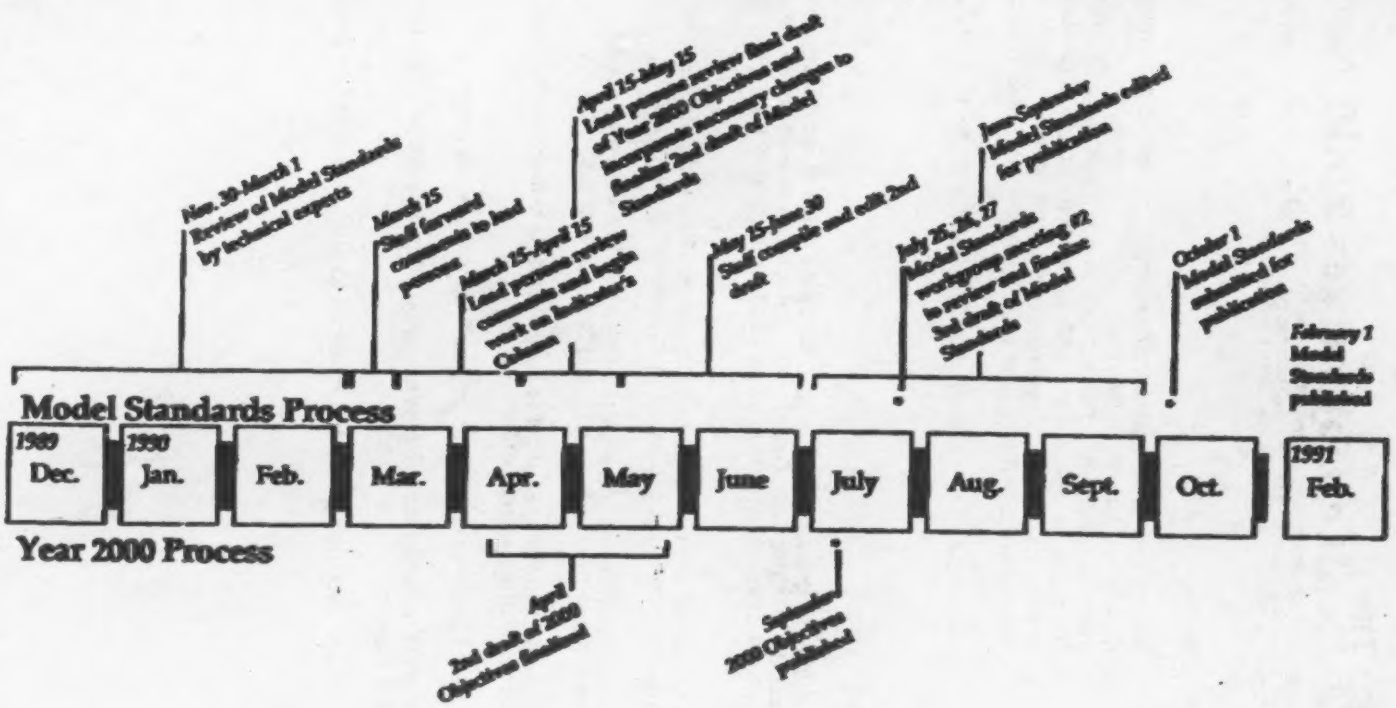
The Objectives and Model Standards are both useful and necessary to the states. They provide both a unifying vision and the tools with which to achieve that vision.

States already have a track record in their attempts to use past documents in planning and programming. With availability of resources targeting national objectives, the states are ready and willing to do more.

Progress toward achieving the objectives has been impaired by the lack of resources to implement this type of planning and to build the information sources states and local departments need for assessing needs, and evaluating progress.

The Health Objectives 2000 Act would provide the needed resources and help to focus our efforts to achieve significant gains in the health status of our citizens.

Thank you very much for the opportunity to testify. I believe in this effort and am gratified to know that you are both interested and supportive.


Nov. 30-March 1
Review of Model Standards
by technical experts
March 15
Staff forward
comments to lead
persons
March 15-April 15
Lead persons review
comments and begin
work on Indicator's
Column
April 15-May 15
Lead persons review final draft
of Year 2000 Objectives and
incorporate necessary changes to
finalize 2nd draft of Model
Standards
May 15-June 30
Staff compile and edit 2nd
draft
July 25, 26, 27
Model Standards
workgroup meeting #2
to review and finalize
3rd draft of Model
Standards
June-September
Model Standards edited
for publication
October 1
Model Standards
submitted for
publication
February 1
Model
Standards
published
Model Standards Process
1989
Dec.
1990
Jan.
Feb.
Mar.
Apr.
May
June
July
Aug.
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1991
Feb.
Year 2000 Process
April
2nd draft of 2000
Objectives finalized
September
2000 Objectives
published

The Health Objectives 2000 Act

A Proposal by the Association of State and Territorial Health Officials
INTRODUCED AS S2056 BY SENATORS HARKIN, HATCH, PELL, DURENBERGER, KENNEDY, COCHRAN, SIMON, KASSEBAUM, BURDICK, KERREY, ADAMS, CHAFEE, GRAHAM, LEAHY AND HATFIELD.

Purpose

- To provide resources states and localities can use to achieve Year 2000 National Health Objectives;
- To create and develop a partnership of federal, state and local health agenices, voluntary health organizations and other health groups for disease and illness prevention initiatives;
- To enable states and localities to address national health policy issues; and
- To assess the health status of the population of the United States.

What will it do?

- Commit $300 million in grants to states specifically earmarked for attainment of the National Year 2000 Objectives. Grants will contain a base amount to each state ($2 million for Missouri), with the balance to be distributed on a per capita basis.

- Require states to submit a National Health Objectives Plan outlining their efforts to attain national objectives to be followed by annual progress reports.

- Require states to address some pre-selected objectives but also give states flexibility in determining their own public health needs and priorities.

- Create incentives and provide resources to states for data collection to track progress toward achieving national objectives.

- Provide resources to fund research, training and demonstration projects.

- Be a sustained effort, enacted for a five-year period with renewal in 1995 for the remainder of the decade.

- Require HHS to administer the grant and make an annual report to Congress.

2/90

QUESTIONS TO DR. GARLAND LAND
Interim Deputy Director
Missouri Department of Health

1. If the National Center for Health Statistics were to suspend the National Health Interview Survey for one or more years, what would be the effect on state health department operations?

2. Would states such as Missouri have to expand their own data collection efforts? Would this be a serious handicap to measuring progress toward the Year 2000 objectives?

Missouri Department of
HEALTH

John Ashcroft
Governor

P.O. Box 570, Jefferson City, MO 65102 • 314/751-6400 • FAX 314/751-6010

April 11, 1990

The Honorable Jeff Bingaman
Chair, Senate Subcommittee on Government
Information and Regulation
United States Senate
502 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Bingaman:

I am pleased to respond to your letter of March 30, 1990 regarding the effect on states of suspending the National Health Interview Survey (NHIS).

The NHIS is one of the cornerstones of health information in the United States. It provides basic information on the incidence of diseases and disabilities along with health care utilization and health behaviors in the U.S. population. There is no other source that can provide comparable information.

State health departments depend on the NHIS to assist in developing local estimates. One of the criteria of utility for any data system is the ability to measure an attribute of current interest. If the NHIS were suspended for one or more years, the data will be several years old before it is available to the states. This seriously compromises our ability to use it for policy decisions.

The states do not have the technical or financial capability to conduct a similar survey as the NHIS. This is a very complex survey which requires the expertise of organizations such as the National Center for Health Statistics.

It has been determined that the NHIS is needed to measure approximately one-fourth of the Year 2000 Objectives. This shows the importance of the NHIS as a national data system. This fact also points out that the Year 2000 Objectives setting process will be seriously damaged if the NHIS data are not available to track the progress. There is no reason to establish objectives if they cannot be measured and tracked.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER
services provided on a nondiscriminatory basis

Honorable Jeff Bingaman
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April 11, 1990

If the NHIS is suspended, then the Year 2000 Objectives need to be reconsidered. It would be unconscionable to not respond to one-fourth of the national health problems or inappropriately respond to the problem because we do not have the data to document the dynamics of the issues.

I understand the present discussions are to just suspend the NHIS for one or two years. I have a grave concern that once the funding for the NHIS is deleted, then it will be very difficult to re-establish funding in the future and the survey could be permanently lost. Another problem is that eliminating the NHIS for a year or two will mean the loss of trained interviewers and other staff. Re-establishing the survey will be more expensive because of the additional training and start-up costs.

I urge you to support the National Center for Health Statistics with sufficient resources to carry out the NHIS and the other important national health data systems.

Sincerely,

Garland Land

Garland Land
Interim Deputy Director

GL:vg

March of Dimes
Birth Defects Foundation
National Public Affairs Office
1725 K Street NW Suite 814
Washington DC 20006
Telephone 202 659 1800

Testimony of

Reed V. Tuckson, M.D.

Senior Vice President for Programs

March of Dimes Birth Defects Foundation

on the

HEALTH OBJECTIVES FOR THE YEAR 2000

Senate Committee on Governmental Affairs

Subcommittee on Government Information

April 6, 1990

We believe it is vital that the nation have reasonable and achievable health goals and objectives. National goals for health will help us define the minimum standard of health in this country. They will help us set priorities and focus our attention and resources appropriately. They will force us to hold ourselves as a nation accountable for our failures. They will allow us to recognize and reward success.

In addition, we believe the goals for the year 2000 will serve as a national symbol of our will and our commitment. They will encourage more people to recognize and to care that this nation is falling behind in the fight against infant mortality. They will encourage more people to care that the gap between the health of black and brown mothers and children and white mothers and children is widening.

We also hope they will help more people recognize and care that low birthweight is increasing after many years of steady decline. And we hope more people will care that the number of women who are not receiving basic medical care during pregnancy is increasing.

Let me comment now on the specific objectives related to maternal and child health. Infant mortality is one of the most basic and important measures of the quality of health in this nation, and the March of Dimes wholeheartedly supports the year 2000 objectives on infant mortality and the related parameters of neonatal mortality, postneonatal mortality, fetal death and maternal mortality.

We are particularly pleased that the goals include specific objectives for people of color. Black babies are dying in this country at twice the rate of white babies. It is our hope that the year 2000 goals will focus attention on the incredible

Good morning, Mr. Chairman and members of the subcommittee. I am Dr. Reed Tuckson, senior vice president for programs for the March of Dimes Birth Defects Foundation, and the former Commissioner of Public Health for the District of Columbia. I appreciate this opportunity to talk with you about health objectives for the year 2000.

I begin with a bias we all may share: the health of the people who inhabit a particular city, state or nation is the most important determinant of the quality of life in that city, state or nation.
As such, disease prevention and health promotion are fundamentally important activities that belong at the top of the policy agenda at every level of government.

As we look at the health indicators in this great nation today, we should be ashamed and resolutely committed to addressing the factors that contribute to disease and death for an unacceptable number of Americans. Nowhere is this more true than in the case of maternal and infant health, and today I will focus my comments on this area that is of great concern to the March of Dimes and to the nation.

The March of Dimes has been pleased to participate in the process of developing the health objectives for the year 2000 over the past year. And we are pleased that hundreds of organizations and thousands of individuals have been involved in developing these goals which truly represent the broad and deep consensus of the American people.

disparity in infant health between Americans of color and their fellow countrymen and women.

The first step in reaching the nation's goals for infant mortality is public education, and we are pleased that this is recognized in the objectives. We fully support the draft objective of increasing to 90 percent the proportion of women 15 to 44 who know that alcohol, smoking and drug use pose risks to the fetus.

However, we suggest that the goals in patient education be expanded to include not only substance abuse, but other risk factors for poor pregnancy outcome such as sexually transmitted diseases, poor nutrition and unintended pregnancy. We recognize that the need for comprehensive health education is addressed in other areas, but feel it is particularly important for women of childbearing age.

For our part, the March of Dimes is actively working to educate the public about the importance of positive health behaviors during pregnancy. We are committed to promoting comprehensive school health education from kindergarten through high school. And we are working directly with many companies and labor unions to provide prenatal education in the workplace.

Professional education also is critically important, and we support the goal of increasing to at least 95 percent the proportion of primary care providers who routinely inform women of childbearing age about the hazards and benefits of certain behaviors. We would hope, however, that the definition of a primary care provider is understood to encompass certified nurse-midwives, nutritionists, health educators and social workers, as well as physicians.

In addition to education, pregnant women need access to basic prenatal care that results in good outcomes. The March of Dimes is strongly in favor of universal access to prenatal care for all pregnant women. However, given the current fiscal situation as well as provider shortages in many areas, we believe 90 percent may be the best we can hope for. We support increasing the proportion of women who get care in the first trimester to 90 percent as a reasonable and achievable goal.

We also are particularly supportive of the important objective of getting women into risk-appropriate care. The March of Dimes is currently involved in a project with the American College of Obstetricians and Gynecologists as well as the American Academy of Pediatrics that is re-examining the issue of regionalization of perinatal care in the current environment.

Genetic screening has long been an area of concern for the March of Dimes. Many of the screening tests discussed in the draft objectives were developed with the help of March of Dimes funding, and we fully support increasing utilization of screening for genetic disorders.

We are concerned, however, about the lack of specific objectives related to congenital anomalies. Birth defects are a major cause of infant mortality. And we hope that the final draft of the objectives will include specific targets for reduction of birth defects.

Another area in which we would like to see objectives added is maternal substance abuse. Over the past few years, maternal substance abuse has become a public health crisis of epidemic proportions. When I served as health commissioner of this city, we made slow but steady progress against infant mortality in the first few years. But in one year those gains have been entirely wiped out by crack cocaine. And we are seeing the same story all across the nation.

While we wholeheartedly support the objective of increasing by 40 percent the number of women who abstain from tobacco, alcohol, cocaine and marijuana during pregnancy, we are concerned that more is needed. Specifically, an objective directed at increasing the proportion of pregnant women who are in treatment for drug abuse would be an ideal compliment to the objective of increasing abstinence. If we recognize that we are not going to increase abstinence to 100 percent, then we need a treatment objective to go with it.

The March of Dimes is working in communities around the country to assist in the creation of drug treatment slots for pregnant women and to develop support services and referral mechanisms. Through our research program, we also are adding to the scientific and clinical skills to make treatment encounters more successful. A national health objective on treatment would help focus attention and track progress against maternal substance abuse.

In closing, let me say that while I have offered many suggestions today, the March of Dimes supports the objectives and the process by which they were developed. We appreciate the interest of Dr. McGinnis and his staff at the Office of Disease Prevention and Health Promotion, and we stand ready to assist them in any way we can.

The year 2000 objectives on maternal and infant health are entirely consistent with the March of Dimes mission. In the nationwide Campaign for Healthier Babies that we are now getting under way, the March of Dimes will use many of the year 2000 goals in setting objectives and priorities for our 134 chapters. We also will carry the message of these goals to Congress and to state elected officials as part of our advocacy and public affairs efforts.

We hope and pray that our efforts will help the nation reach its health objectives for the year 2000. And we hope and pray that the process of developing and establishing these objectives will help us someday reach our goal of a healthy birth for every baby. Thank you.

Statement

Before the

Subcommittee on Government Information and Regulation
Governmental Affairs Committee

by

Sanford F. Kuvin, MD

Vice Chairman

Board of Trustees
The National Foundation for Infectious Diseases

April 6, 1990

My name is Sanford Kuvin. I am Vice Chairman of the Board of Trustees of the National Foundation for Infectious Diseases in Washington and am also Clinical Associate Professor of Medicine at the Uniformed Services University in Bethesda, and at the University of Miami Medical School. I am also Chairman of the International Board of the Sanford Kuvin Center for the Study of Infectious and Tropical Diseases at the Hebrew University Medical School in Jerusalem. I would like to request that my written statement be made part of the record.

My purpose in being here today is to help this committee in its deliberations about the Federal Health Benefits Program and to inform you of a national tragedy incubating in the United States because of failure to develop a national program to vaccinate targeted groups against hepatitis B. Our Public Health Service objectives for the year 2000 include a significant reduction in hepatitis B in all targeted groups including 90% vaccination in all health care personnel. Are these objectives obtainable? Certainly yes—but they will most certainly not be reached with the current national apathy, ignorance at the public level, lack of professional education, lack of public programs and public funding, in addition to the costs of the vaccine.

We must ask ourselves—

Isn't it true that hepatitis B is the most important chronic viremia in the world today bar none including AIDS?

And isn't it also true that over 25% of chronic carriers of hepatitis B progress onto primary liver cancer—therfore this vaccine which prevents hepatitis B in well over 90% of those vaccinated also prevents primary liver cancer—and therefore its undoubtedly the world's first anticancer vaccine ever produced.

The United States is going through an epidemic of both AIDS and hepatitis B—with hepatitis B almost unnoticed with 300,000 new infections reported in 1989, and with an estimated 1.5 million chronic carriers of this disease in the U.S.

There are almost 300 million chronic carriers world-wide. There have been 26 cases of HIV AIDS infections reported in health care workers globally since 1982—but over 12,000 infections with hepatitis B were reported in health care workers in the United States this past year alone—and with 250 deaths from the complications of either hepatitis B, primary liver cancer or fatal cirrhosis. This amounts to almost a needless death a day in un-vaccinated American health care workers. This is also the first time in the history of the United States that the introduction of a safe and effective vaccine did not lower the incidence of disease. All because of apathy, ignorance, lack of professional education, lack of national programs and excessive cost of the hepatitis B vaccine.

The facts are that only 1% of the infections of hepatitis B are in health care workers, and this group has received 80% of the 2.5 million doses of vaccine used in this country thus far. Sadly, only 40% of all health care workers have been vaccinated, and shockingly less than 24% of all physicians have received the vaccine.

This means that the current strategies for hepatitis B vaccination are simply not working and that no programs have been initiated for the largest targeted groups affected—namely sexually active heterosexuals who number about 22% of infections, IV drug abusers who number 26% of cases, and homosexuals who number about 5%. Thirty-percent (30%) of infections of hepatitis B are in the unknown category of risk factors—but sexually active heterosexuals are the fastest growing group in this so-called "unknown" category. The other major groups affected are the newborns of surface antigen-positive pregnant women, eskimos, prisoners, institutionalized mental patients, and Asian and African immigrant groups. About 30 million Americans need vaccination today.

Several scattered actions have been implemented in the United Sates which are encouraging—but fall far short of a significant step forward. The "Ohio Plan" requires all dentists in that state to be immunized or show evidence of immunity to hepatitis B in order to be licensed. The "Yale Plan" requires vaccination of medical students in their clinical years, but this plan has spread to only 30% of medical schools. Michigan is the first state in the nation to recently pass a state law requiring prenatal screening of hepatitis B, and OSHA has recommended its first biomedical science regulation ever to protect all workers against hepatitis B and other blood-borne pathogens. Only recently Congress appropriated $10 million to be administered by the Centers for Disease Control for state public health use in controlling the perinatal transmission of hepatitis B.

A systemized "call to action" to vaccinate all targeted groups in America can be carried out at the Federal, the State, and the Regulatory level—but only with your help.

At the federal level, this include legislation requiring free immunization for all health care workers, universal coverage by Medicaid and other federal health insurance programs for all infants and adolescents, Immigration and Naturalization Service sponsored vaccination of all immigrants from high endemicity areas, vaccination for new military recruits, increased funding for Sexually Transmitted Disease clinics, and increased funding for cost-effective studies for the universal vaccination of all infants, all adolescents, and other high risk groups. Needed regulatory initiatives include encouraging the Centers for Disease Control and the Advisory Committee on Immunization Practices to implement universal vaccination of infants and adolescents, implement OSHA requirements for workers at risk--including emergency personnel, and include hepatitis B in all AIDS education prevention programs, grants and contracts. At the state level legislation should require free vaccination for all state health care employees, place hepatitis B vaccine on the Medicaid formulary, require perinatal screening and newborn vaccination, and produce evidence of immunization or immunity for all health care students graduating from state schools, for health care students prior to clinical training, and for all health care professionals in state-funded institutions.

If we have no hepatitis B in the United States then we will not play catch-up with the enormous prevalency rates in the rest of the world where primary liver cancer ranks amongst the most common of all cancers. There are national hepatitis B vaccination programs going on in over 22 countries of the world, but no national program as yet in the United States. The hepatitis B virus like the AIDS virus recognizes no international border, and doesn't need a passport or visa. Hepatitis B is spread by exactly the same methods as AIDS—blood sex, needles, and birth—but unlike AIDS the hepatitis B virus is far more contagious. If you are pricked with AIDS contaminated blood, your chance of getting AIDS is less than one-half of one percent (1/2 of 1%). If your pricked with hepatitis B contaminated blood, your chance of getting hepatitis B are between twenty-seven (27%) and forty (40%) percent. Also, unlike AIDS, this is the first time we are in front of a virus in the U.S., and our medical intelligence is excellent.

We are developing the weapons against AIDS—we have developed the weapon against hepatitis B.

The great American public health physician Herman Biggs, said at the turn of the century, "Public health is purchasable. Within natural limitations, any community can determine its own death rate."

I am no political scientist, but I am a medical scientist and a physician—and I believe that this coordinated "call to action" by the National Foundation for Infectious Diseases to fully utilize this safe and effective vaccine is the best prescription I know of to protect the health of the American people against this disease and meet the objectives of the Public Health Service for the year 2000.

STATEMENT ON HEALTH PROMOTION

by

STANLEY G. KARSON
DIRECTOR
CENTER FOR CORPORATE PUBLIC INVOLVEMENT

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

and the

AMERICAN COUNCIL OF LIFE INSURANCE

before the

SUBCOMMITTEE ON GOVERNMENT INFORMATION AND REGULATION

of the

SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS

April 6, 1990

Mr. Chairman and members of the Subcommittee, my name is Stanley G. Karson. I am Director of the Center for Corporate Public Involvement, an 18-year program of two insurance trade associations, the Health Insurance Association of America (HIAA) and the American Council of Life Insurance (ACLI). The Center works with and for almost 700 health and life insurance companies across the country on their community and social projects, with a particular emphasis on health and wellness, AIDS, education, the elderly, the hard-to-employ, housing, and hunger and the homeless.

In 1977, the industry body of CEOs that directs the Center's operations, the Committee for Corporate Public Involvement, agreed that health education and promotion should be a priority concern of this industry. At that time, more than a decade ago, in spite of research findings and public health advice, efforts to encourage behavior change to reduce health risk factors in our society were both controversial and scattered. Smoking restrictions, let alone bans, were in place in few businesses or public places. Those promoting programs to attack obesity and improper diet were often labelled a fad fringe, not to be taken seriously by the mainstream health and medical community.

In order to provide the most professional and expert guidance to the industry in this then emerging field in the late '70s, we established the Advisory Council on Education for Health (recently renamed the Advisory Council on Health Promotion), a group of outstanding men and women widely respected in this health area. A list of its membership from that time to the present is attached. I am confident most or all are well-known to this Subcommittee. They include: Assistant Secretary for Health Dr. James Mason;

former Assistant Secretaries Drs. Ed Brandt and Monte DuVal; Drs. Jonathan Fielding, Charles Berry and Robert Levy; and Anne Somers of Rutgers and Princeton.

Out of the first meetings of this group came a consensus that if the industry wanted to make notable contributions to the cause of disease prevention, leadership was indicated in two areas: smoking cessation and the role of the primary care physician in health risk reduction.

Now in 1990, when anti-smoking campaigns have become the norm in the nation, our industry's part in alerting first our employees and then our corporate and individual policyholders to the perils of tobacco may not be fully appreciated. Time does not permit me to cite the details of our early record in the anti-smoking campaign in this country but I think you would be interested in two figures from the 1989 Social Report of the Center for Corporate Public Involvement: 84% of the reporting life and health insurance companies had non-smoking restrictions in effect at their home offices, and 36% had instituted a total ban on smoking in their buildings.

Turning to the other health promotion priority recommended to the industry by our Advisory Council almost ten years ago, the impact of the primary care physician on the reduction of risk factors on his or her patients was then unclear, if not disputed. Whether the doctors were willing, even able, to make a concentrated effort to advise and counsel patients to this end and whether patients would accept this intervention was not known. And no credible group or institution -- public or private -- was about to undertake a study to see if this were feasible.

At the same time, it was generally accepted that the primary care physician was in a uniquely trusted position. To find out whether and how these doctors could affect the health behavior of millions loomed as a mighty challenge.

Thus was launched the Lifecycle Preventive Health Services Study -- undertaken by INSURE, an industry-sponsored non-profit organization -- funded by 88 member companies of ACLI and HIAA and the two associations themselves, together with The Robert Wood Johnson Foundation, The Kaiser Family Foundation, the MacArthur Foundation and later by the U.S. Department of Health and Human Services.

The INSURE Project began in 1982 as a feasibility study, and in 1984 the Project was extended to evaluate long-term, behavioral risk reduction among adult patients in primary medical care. As part of a quasi-experimental design, age and sex specific preventive intervention was provided by group practice physicians at study sites, and behavioral risk changes among study site patients were compared to changes among control patients at reference sites using patient survey data. The initial pre- and post-intervention patient surveys showed that adult study patients at risk were more likely to report positive changes after one year than reference site, at-risk control patients. These early results suggested that preventive services, explicitly including risk factor education and counseling by primary-care physicians, can improve the short-term, health-related behavior of adult patients. The preventive intervention and patient surveys were continued at study and reference sites over the next five years to determine the long-term effectiveness and costs of preventive services in primary care.

To address behavioral risk factors in primary care, the INSURE Project developed a model for preventive intervention by physicians that included both selective clinical procedures for early disease detection and patient education for risk factor reduction. The preventive intervention was based on reports in the medical literature, as well as educational and behavioral theory that could be adapted to fit into the primary care physician's office practice. Reinforcement of the physician's preventive intervention was provided by a systematic follow-up program.

Participating physicians routinely used the INSURE preventive prescriptions for the study patients, and two-thirds of the physicians responded that as a result of the Project they felt better prepared and more effective in educating their patients about reducing risk factors. Eighty-five percent of the physicians said they were likely to use the INSURE procedures with non-study patients. Eighty-three percent said the INSURE Cardiovascular Disease-Health Risk Appraisal (CVD-HRA) was useful for their patients, and 74 percent indicated they would like to see CVD-HRA become a regular part of patient care.

The INSURE Project negotiated and paid usual and customary fees for the physicians' services, laboratory and x-ray procedures (including mammography) and the physicians' time in educating study patients about risk reduction. The cost of adult preventive care provided under the INSURE Project increased from $104 to $108, or four percent, for an average patient visit over the five-year period. If INSURE preventive care had been covered by health insurance in 1987, the premium would have risen by an estimated two to four percent as a result.

Initially, 37 percent of the randomly-selected patients of all ages chose to participate in the Project. After two years, 58 percent of the adult patients opted for the second preventive care visit, while 46 percent took part in the third INSURE visit. Surveys of patients at the end of the study revealed that 88 percent were interested in insurance coverage for preventive care and that 84 percent would choose an insurance plan with a $10 co-payment for preventive care visits.

Where are we now as an industry, both with the INSURE Project and with health promotion and disease prevention in general? The Project was concluded successfully in 1988; the results were published recently in the American Journal of Preventive Medicine.

It is too soon to tell whether insurance companies will eventually implement the findings of the Project, whether they will fashion products to cover preventive care and market them aggressively. Currently, although some companies can point to trials or pilots or options for policyholders who want such coverage, companies have been admittedly slow in introducing new policies using the INSURE Project guidelines.

The stated reason is that the current costs of health insurance serve to tip the scales in the other direction: to reduce costs to group policyholders rather than add new benefits.

The competitive factor in group insurance does not encourage add-ons in policies these days. Or that is the view of those on the firing line in our companies.

Unless, of course, the customer demands it, or companies can find ways of offering preventive care benefits without increasing costs, for example, by providing it as one option among other benefits or by having the employee absorb all or most of the cost.

And, for those of us who believe that reducing risk factors through preventive care reduces claims, costs may well be reduced too.

As for health promotion as a larger issue, our industry still maintains its commitment. The HIAA has a reinvigorated Committee on Prevention and Public Health Policy under the direction of Dr. Charles Arnold of Metropolitan Life. Many insurance companies have developed and supported innovative health promotion programs for employees, policyholders and the general public. The industry's annual Social Report shows that employee benefits such as fitness facilities, AIDS education and hypertension screening are widely available. And one company, Metropolitan Life, has been a national model for support of health promotion throughout this century, first with visiting nurses programs and more recently through assisting comprehensive health education in the nation's public schools.

Today, the Advisory Council on Health Promotion has a somewhat broadened mission with the encouragement of association executives Carl Schramm and Dick Schweiker. Its priorities, consequently its guidance to the industry, concentrate on three areas of continued concern to the business: health promotion for the elderly; health risks of low-income, minority populations; and quality of life issues which include the environment, violence, drug and alcohol abuse and the homeless.

It has become all to clear to those of us working in this field that low-income and minority populations are at the highest health risk while being the most underserved in health promotion information. For this reason and also because many in those groups are in the ranks of the uninsured, the HIAA and ACLI boards have approved a new health promotion priority for the industry: the health risks of low-income/minority Americans. A subcommittee of our Advisory Council, chaired by Dr. Robert Murray, Jr. of Howard University School of Medicine, will be deliberating this spring to recommend approaches and activities to our member companies to address this critical population.

Finally, our industry has had a major role in creating the concept and the existence of wellness councils in many areas of the country. Begun in the early '80s in Omaha, Nebraska, under the leadership of William M. Kizer, CEO of a health and life insurance company there, it has expanded to a number of cities and regions. The purpose of these wellness councils is to encourage and coordinate the health promotion programs of employers -- private and public -- in a given area. We are aware of and grateful for the critical support of the Chairman, Senator Bingaman, in setting up a similar group of employers and others concerned with worksite health education programs in New Mexico.

Just this year, both the HIAA and ACLI have provided needed funding to continue the operations of the Wellness Councils of America (WELCOA), the national umbrella organization of the local wellness councils. We strongly hope others will see the worth of this approach to health promotion.

While the health and life insurance industry is proud of its early and consistent leadership in health education and promotion, we fully realize that the improvement of the health of the American people is an enormous and continuing challenge. It is beyond the means of any one segment of society -- public or private. That is why we have worked with the U.S. Department of Health and Human Services in the development of the Year 2000 Health Objectives for the nation. They must be better known, understood and implemented if our mutual goals of better health and quality of life for all Americans are to be attained.

The health and life insurance industry stands ready to continue to work for these objectives. Thank you, Mr. Chairman.

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of the Health and Life Insurance Business
(Formerly Advisory Council on Education for Health)
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1990

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STATEMENT

by

ROBERT S. LAWRENCE, M.D.

DIRECTOR, DIVISION OF PRIMARY CARE

HARVARD MEDICAL SCHOOL, and

CHIEF OF MEDICINE, CAMBRIDGE HOSPITAL

BEFORE THE COMMITTEE ON GOVERNMENTAL AFFAIRS

SUBCOMMITTEE ON GOVERNMENT INFORMATION AND REGULATION

UNITED STATES SENATE

April 6, 1990

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to be here today to discuss the Year 2000 Objectives for the Nation of the Public Health Service, and the need for information to monitor the attainment of the objectives. I am Robert S. Lawrence, M.D., Director of the Division of Primary Care at the Harvard Medical School and Chief of Medicine at the Cambridge Hospital. From 1984 to 1989 I had the privilege of chairing the U.S. Preventive Services Task Force, a group which developed clinical preventive services recommendations for the Office of Disease Prevention and Health Promotion of the Public Health Service.

I have been asked to comment on whether the Year 2000 Objectives are reasonable, measurable and attainable; whether they target specific populations realistically; what areas of research should be pursued in order to reach these objectives; and whether the problems of community health promotion are realistically addressed in the plan. The best current measure of the appropriateness and feasibility of the Year 2000 Objectives lies within an examination of the utility of the 1990 Objectives. The publication of Healthy People in 1979 represented the first comprehensive federal report on health promotion and disease prevention. It recognized the new morbidity of a large burden of preventable or postponable death and disease caused by unhealthy personal behaviors, environmental hazards and barriers to access to health care. It set the stage for developing the 1990 Objectives by identifying the major areas where the health of the nation needed improvement. In 1980 the Public Health Service identified 15 priority areas within three major categories:

Preventive Services for Individuals

- High blood pressure control

- Family planning
- Pregnancy and infant health
- Sexually transmitted diseases

Health Protection for Population Groups

- Toxic agent and radiation control
- Occupational safety and health
- Accident prevention and injury control
- Fluoridation and dental health
- Surveillance and control of infectious diseases

Health Promotion for Population Groups

- Smoking and health
- Misuse of alcohol and drugs
- Nutrition
- Physical fitness and exercise
- Control of stress and violent behavior

The process for developing objectives in these priority areas was very much top-down. Various government agencies (NIH, CDC) developed background papers for a conference of health experts. The experts in turn used a consensus process to develop the objectives which were then sent to more than 2000 groups for review and comment. The final publication, Promoting Health/Preventing Disease: Objectives for the Nation, contained 226 specific objectives in the 15 priority areas.

These objectives were quite heterogeneous. Some were statements of ideal health conditions, and as such might serve to challenge the nation's health leadership but were hardly useful for managing-by-objective. Other objectives were feasible if appropriate strategies could be developed and the necessary resources made available. The remaining objectives could be regarded as probable outcomes, even if no changes occurred in the way health promotion/disease prevention services were delivered. Like the ideal objectives, the probable objectives lacked managerial or planning power. Clearly, the lesson to be learned here is that the Year 2000 Objectives should focus on feasible outcomes while placing little or no emphasis on the unrealistic, ideal objectives or the probable, secular trend objectives.

The mid-course review of 1985 produced mixed results. Encouraging results were seen in the priority areas of hypertension control, immunizations, control of sexually transmitted disease (with the notable exception of AIDS), toxic agent and radiation control, accident prevention, infectious disease control (again with the notable exception of AIDS), smoking cessation, and control of stress and violent behavior. The results for family planning, maternal and child health, occupational safety and health, nutrition, and physical fitness and exercise were very disappointing. Several of these latter priority areas reflect ideologic disagreements and the lack of a national consensus on such critical issues as sex education, the availability of contraceptives, the right to access to prenatal care, and the appropriateness of strict standards for protecting the health of workers.

The 1990 Objectives have served a useful purpose in bringing into sharper focus the need to debate and resolve these ideologic differences in the interests of the health of the American people. The discrepancy between the health status of minority groups compared with the majority population remains unacceptably large. The infant mortality rates, both national and for our minority groups, continue to be a disgrace. At the same time we continue to spend a greater proportion of our GNP on health care than any other industrialized society while the numbers of our citizens who are uninsured or underinsured continue to grow.

The process of developing the Year 2000 Objectives has clearly benefitted from the experience with the 1990 Objectives. The new objectives are equally comprehensive while reflecting a broader participation in their development, relying more on a bottom-up approach. As you heard from Assistant Secretary of Health James Mason on March 20, there was greater involvement of local government and private agencies through the hearings conducted in different regions of the country by the Institute of Medicine and the U.S. Public Health Service. More than 7000 individuals have contributed commentary or review on 21 priority areas containing 339 objectives in the draft report. Important omissions have been corrected with the inclusion of sections on HIV, cancer and functional status of the elderly. A fourth priority area, Systems Improvement, was added to emphasize the importance of addressing the problems of the delivery system in order to achieve the objectives in Preventive Services, Health Protection for Population Groups and Health Promotion for Population Groups.

The criteria for the Year 2000 Objectives are more explicit, and therefore, should be more accurately measured. Unfortunately, some variations persist in the statistical methods used and in the expression of data. Every effort should be made in editing the final version to eliminate those objectives where baseline values or target values are not available or not stated. Similarly, those objectives that are unmeasurable should be deleted to enhance the effectiveness of the document as a management-by-objectives instrument. It is critically important to have a consistent, reproducible approach to data collection and interpretation to assure credibility, clarity of communication, and the setting of standards. We learned in the work of the U.S. Preventive Services Task Force that the adoption of a common methodology to assess the quality of the evidence regarding the efficacy and effectiveness of a given preventive service was essential to the formulation of coherent policies.

The quality of the information on health promotion depends on close attention to the following statistical challenges:

- the inclusion of baseline date for all objectives
- avoidance of vague or unmeasurable objectives
- precise identification of target groups
- internal consistency for data presentation
- uniform definitions of measurement perameters
- use of absolute targets, expressed as rates
- choice of target values based on trend analysis
- adoption of standard methods for national, state and local data collection

The 1990 Objectives were not given a priority ranking. This is understandable given that the process was new and the effort expended was enormous. The Year 2000 Objectives, however, should be ranked by priority to improve their effectiveness as a management tool. The health status and risk reduction objectives deserve highest priority. The public awareness, professional education and awareness, and services objectives are important for achieving the national health status objectives but are not, properly speaking, objectives themselves. Rather they are enabling factors critical to achieving the objectives.

The objectives must be linked to existing data sources to assure the availability and reliability of data to monitor progress. The National Health Interview Survey is the single most important component of the national surveillance system required for the accurate assessment of progress toward the objectives. The Behavioral Risk Factor Survey performed at the state level is next in importance for the successful use and interpretation of the health promotion/disease prevention objectives. Unless the proposed level funding for the National Center for Health Statistics is altered to provide appropriate inflation adjustments I have serious doubts that the National Health Interview Survey will continue in its current form. Without it the entire planning and management value of the Year 2000 Objectives will be severely compromised. We have learned too much from the 1990 Objectives, and the burden of premature disease, disability and death is too great among the American people for us to take that chance. Only through maintenance and improvement of current data systems will we be able to evaluate the effectiveness of health promotion interventions and judge the efficacy of research interventions.

Thank you for this opportunity to present my views. I will be pleased to respond to any questions that you might have.

TESTIMONY OF CLAUDE EARL FOX, M.D., M.P.H.
UNITED STATES SENATE GOVERNMENTAL AFFAIRS SUBCOMMITTEE ON GOVERNMENT INFORMATION AND REGULATION
APRIL 6, 1990

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, THANK YOU FOR THE OPPORTUNITY TO ADDRESS YOU ON BEHALF OF THE STATE AND TERRITORIAL HEALTH OFFICIALS RELATIVE TO THE PUBLIC HEALTH SERVICE'S YEAR 2000 OBJECTIVES FOR THE NATION, AND THE CAPABILITY OF THE STATES TO MONITOR PROGRESS TOWARD ACHIEVEMENT OF THOSE OBJECTIVES. I APPRECIATE YOUR INTEREST IN WHAT IS CURRENTLY A SUBJECT OF GREAT DISCUSSION AND ACTIVITY IN THE PUBLIC HEALTH COMMUNITY AND I HOPE TO BE ABLE TO ADDRESS THOSE QUESTIONS WHICH HAVE BEEN FORWARDED TO ME AS WELL AS ANY YOU MAY HAVE TODAY.

PRELIMINARY TO A DISCUSSION OF THE QUESTIONS, HOWEVER, I WOULD LIKE TO COMMENT THAT FOR A NUMBER OF YEARS THE PUBLIC HEALTH FOUNDATION, ESTABLISHED BY THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS, HAS PROVIDED A MECHANISM TO THE STATES THROUGH WHICH TO DOCUMENT LEVELS OF ACTIVITY IN VARIOUS PROGRAM AREAS, AS WELL AS FISCAL INFORMATION ON PUBLIC HEALTH EXPENDITURES. THEIR REPORTS AND NEWSLETTERS, PUBLISHED ANNUALLY, PROVIDED A NATIONAL SNAPSHOT OF THE PROCESSES OF PUBLIC HEALTH, ENABLING CONGRESS AND OTHER NATIONAL POLICY MAKERS TO HAVE A BASIS ON WHICH TO ALLOCATE SCARCE RESOURCES, AS VERY OFTEN INFORMATION GATHERED WAS IN RESPONSE TO FEDERAL REQUIREMENTS. THE INFORMATION WAS ALSO USEFUL TO HEALTH OFFICIALS AT THE STATE AND LOCAL LEVEL TO CONDUCT PROCESS EVALUATIONS OF PROGRAM EFFORTS.

A FEW YEARS AGO, HOWEVER WE BEGAN TO REALIZE THE IMPORTANCE OF

DEVELOPING A FOCUS ON NATIONAL PUBLIC HEALTH PRIORITIES. WE ALSO REASONED THAT WHILE PROCESS WAS AND CONTINUES TO BE IMPORTANT, WE MUST SEEK, IN FACT, TO MEASURE OUR PROGRESS IN TERMS OF IMPROVED HEALTH OUTCOMES. THIS OUTCOME-ORIENTED EVALUATION COMPONENT REQUIRED THE ESTABLISHMENT OF A UNIFORM NATIONAL DATA SET THAT WOULD, RELATIVE TO STATED OBJECTIVES, PERMIT VALID COMPARISONS AMONG THE STATES. THIS APPROACH WAS CITED AS A RECOMMENDATION BY THE INSTITUTE OF MEDICINE'S REPORT ON "THE FUTURE OF PUBLIC HEALTH."

THE IDENTIFIED NEED SPURRED CONSIDERABLE ACTIVITY LED BY THE PUBLIC HEALTH FOUNDATION WHICH HAS TO DATE CONVENED WORK GROUPS TO ESTABLISH MINIMUM DATA SETS ON NINE GOALS ENCOMPASSING MANY OF THE YEAR 2000 OBJECTIVES. OTHER PARTIES AT WORK ON THE DATA ISSUE, EITHER CONCEPTUALLY OR ACTUALLY, INCLUDE THE CENTERS FOR DISEASE CONTROL, NATIONAL CENTER FOR HEALTH STATISTICS, THE AMERICAN PUBLIC HEALTH ASSOCIATION, THE SCHOOLS OF PUBLIC HEALTH, STATE HEALTH PLANNING AGENCIES, THE NATIONAL OFFICE OF MATERNAL AND CHILD HEALTH, THE ASSOCIATION OF MATERNAL CHILD HEALTH DIRECTORS, THE COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, THE ASSOCIATION FOR VITAL RECORDS AND HEALTH STATISTICS, AND OF COURSE THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS. THE FRAMERS OF THE YEAR 2000 OBJECTIVES DEMONSTRATED THEIR UNDERSTANDING OF THE IMPORTANCE OF MONITORING PROGRESS BY INCLUDING A SEPARATE SECTION DEVOTED TO SURVEILLANCE AND DATA NEEDS, AND IN ADDITION INCLUDED AT LEAST ONE DATA RELATED OBJECTIVE IN EACH OF THE OTHER TWENTY PRIORITY AREAS. IN SUMMARY, THERE IS A SHARED COMMITMENT TO IMPROVED DATA COLLECTION AND INFORMATION SYSTEMS WHICH WITH PROPER FISCAL SUPPORT CAN ALLOW US TO MOVE FORWARD RAPIDLY AND ESTABLISH A STATE OF THE ART RESPONSE NETWORK.

I WILL NOW RESPOND TO THE QUESTIONS PROVIDED TO ME EARLIER. IN REFERENCE TO THE VALIDITY OF THE YEAR 2000 OBJECTIVES, I WOULD COMMEND THE AUTHORS OF THE DRAFT ON THEIR EXTENSIVE EFFORTS TO RECEIVE FEDERAL, STATE, AND LOCAL INPUT TO ESTABLISH THOSE OBJECTIVES SELECTED FOR PUBLICATION RELATIVE TO PRIORITY PUBLIC HEALTH PROBLEMS. THEIR WORK CARRIED THEM TO A NUMBER OF SITES THROUGHOUT THE NATION WHERE STATE AND LOCAL PEOPLE WERE ENCOURAGED TO PROVIDE INPUT. SEVERAL DRAFTS WERE CIRCULATED FOR COMMENT TO EXPERT GROUPS AS WELL AS TO PUBLIC HEALTH PROVIDERS IN GENERAL. WHILE NOT ALL INCLUSIVE, IT IS OBVIOUS THAT A MONUMENTAL EFFORT HAS GONE INTO DEVELOPING AND REFINING THE OBJECTIVES AND I UNDERSTAND THE FINAL DOCUMENT, SCHEDULED FOR RELEASE IN SEPTEMBER, WILL BE EVEN MORE WELL DEVELOPED.

IN ADDRESSING THE ISSUE OF WHETHER OR NOT THE OBJECTIVES ARE MEASURABLE, ONE MUST LOOK AT TWO DEFINITIONS OF MEASURABILITY. THE FIRST DEFINITION REQUIRES A BASELINE FROM WHICH TO ASSESS PROGRESS. THE LATEST DRAFT POINTS OUT THAT ONE HUNDRED TEN OF THE OBJECTIVES DO NOT, IN FACT, HAVE BASELINE DATA AND THAT TWENTY-EIGHT SPECIAL POPULATION GROUPS HAVE NO BASELINE DATA AT ALL. AFTER MUCH DELIBERATION AND PRIOR TO DEVELOPMENT OF THE OBJECTIVES THE DECISION WAS MADE TO PURPOSELY INCLUDE OBJECTIVES

WHICH REFLECT PRIORITY PUBLIC HEALTH PROBLEMS, DESPITE THE FACT THAT NO BASELINE DATA EXISTED. FAILURE TO INCLUDE SUCH OBJECTIVES WOULD CREATE A FALSE IMPRESSION THAT CERTAIN EMERGING PROBLEMS WERE OF LESS IMPORTANCE. PLEASE WITNESS THAT IN 1980 WE HAD VIRTUALLY NO BASELINE DATA ON INCIDENCE OF HIV INFECTION OR ON CERTAIN CATEGORIES OF DRUG ABUSE SUCH AS CRACK AND COCAINE USAGE, YET THOSE PROBLEMS BECAME OF PARAMOUNT IMPORTANCE DURING THE DECADE. THE SECOND DEFINITION OF MEASURABILITY MIGHT BE "THAT WHICH LENDS ITSELF TO A FORM OF MEASUREMENT." I THINK YOU WILL FIND THAT MOST OBJECTIVES ARE MEASURABLE BY THAT DEFINITION EITHER BY DIRECT OR SURROGATE OUTCOMES.

THE SECOND QUESTION I WILL RESPOND TO ASKS IF NATIONWIDE DISEASE PREVENTION EFFORTS WERE AIDED BY PUBLICATION OF NATIONWIDE OBJECTIVES. I MUST SAY THAT THE REVIEWS ON THE IMPACT OF THE 1990 OBJECTIVES INDICATE IN MANY CASES DISAPPOINTMENT AT OUR FAILURE TO ACHIEVE SOME OF THE HIGHEST PRIORITY OBJECTIVES, HOWEVER THERE SEEMS TO BE UNIVERSAL AGREEMENT THAT THE ESTABLISHMENT OF THE OBJECTIVES WAS USEFUL BOTH IN TERMS OF SETTING TARGETS FOR PROGRAM MANAGEMENT AND IN ALLOWING FOR COMPARISON AMONG THE STATES. FOR EXAMPLE, A SOUTHERN GOVERNORS' ASSOCIATION'S MAJOR INITIATIVE WAS ENTITLED "NINE BY NINETY", A DIRECT REFLECTION OF THE INFANT MORTALITY GOAL. PERSONALLY, I FIND THE DRAFTS OF THE YEAR 2000 OBJECTIVES WHICH I HAVE STUDIED TO BE BETTER FRAMED THAN THOSE FOR 1990 AND AS STATED EARLIER, OUR NEEDS FOR IMPROVED DATA COLLECTION EFFORTS HAVE BEEN HIGHLIGHTED DURING THE DECADE.

I HAVE BEEN ASKED HOW STATE AND LOCAL AGENCIES ARE AFFECTED BY IMMIGRATION AND POPULATION SHIFTS. IN PLANNING FOR A DECADE OF DELIVERY OF PUBLIC HEALTH SERVICES ONE MUST REASON THAT IN CERTAIN STATES, AND MANY TIMES UNPREDICTABLY, AN INFLUX OF INDIVIDUALS IN NEED OF SERVICES MAY OVERLOAD THE SYSTEM. THE MOST GLARING EXAMPLE OF A MAJOR MOVEMENT IS PROBABLY THAT OF MEXICAN NATIONALS INTO CALIFORNIA, ALTHOUGH DURING THE 1980'S THERE HAS BEEN SIGNIFICANT MOVEMENT FROM THE INDUSTRIALIZED NORTH TO THE DEEP SOUTH, AND OF COURSE FLORIDA CONTINUES TO BE IMPACTED BY THE CUBAN REFUGEES. IN SHORT, BOTH INDIVIDUAL STATES AND THE FEDERAL AGENCIES MUST CLOSELY MONITOR THESE PATTERNS AND ACCOMMODATE THEM WITH SUCH PROGRAMS AS THE STATE LEGALIZED IMPACT ASSISTANCE GRANTS ADMINISTERED BY THE DHHS OFFICE OF REFUGEE RESETTLEMENT. THOSE GRANT DOLLARS WERE APPROPRIATED TO AUGMENT STATES' ABILITY TO PROVIDE PREVENTIVE HEALTH SERVICES TO PERSONS WHO BECOME CITIZENS DURING THE MAJOR POPULATION SHIFT FROM SOUTH AND CENTRAL AMERICA DURING THE LAST FIFTEEN YEARS. SEVERAL STATES HAVE RECEIVED SUCH GRANTS.

THE NEXT QUESTION ASKS ARE DATA AVAILABLE OR OBTAINABLE AT STATE AND LOCAL LEVELS TO MONITOR PROGRESS TOWARD THE YEAR 2000 OBJECTIVES. IN LATE 1989, THE PUBLIC HEALTH FOUNDATION CONDUCTED A SURVEY OF THE STATES WHICH POSED THE QUESTION OF AVAILABILITY. A RESPONSE WAS ASKED FOR EACH OBJECTIVE IN EACH OF THE TWENTY-ONE PRIORITY AREAS INCLUDED IN THE DRAFT OBJECTIVES DOCUMENT, SOME 637 OBJECTIVES IN ALL. THIRTY-NINE STATES COMPLETED A SURVEY FORM FOR TWENTY-ONE PRIORITY AREAS; AN ADDITIONAL NINE STATES RESPONDED TO

FIFTEEN PRIORITY AREAS. PRELIMINARY ANALYSIS OF THE RESPONSES REVEAL THAT THE PRIORITY AREAS FOR WHICH DATA WERE MOST FREQUENTLY AVAILABLE FROM THE STATES INCLUDED PREVENTING UNINTENTIONAL INJURIES, IMPROVING INFANT AND MATERNAL HEALTH, REDUCING SEXUALLY TRANSMITTED DISEASES, AND IMPROVING SURVEILLANCE AND DATA SYSTEMS. STATES ARE ABLE TO PROVIDE DATA FOR 59%, 67%, 69%, AND 65% OF THE OBJECTIVES IN EACH OF THESE PRIORITY AREAS, RESPECTIVELY. ON THE OTHER END OF THE CONTINUUM, STATES WERE ABLE TO PROVIDE DATA FOR 30% OR FEWER OF THE OBJECTIVES IN FIVE OF THE PRIORITY AREAS INCLUDING IMPROVING NUTRITION (24%); INCREASING PHYSICAL ACTIVITY (30%); MAINTAINING THE VITALITY AND INDEPENDENCE OF OLDER PEOPLE (30%); IMPROVING ORAL HEALTH (25%); AND IMPROVING EDUCATION AND PREVENTIVE SERVICES (20%). FURTHER ANALYSIS OF THE DATA WILL DETERMINE POTENTIAL REGIONAL VARIATIONS IN STATE DATA COLLECTION CAPABILITIES; VARIATIONS BETWEEN THE AVAILABILITY OF DATA FOR PROCESS AND OUTCOME OBJECTIVES, AND DIFFERENCES IN THE AVAILABILITY OF DATA FOR MINORITY POPULATIONS. ONE MUST ALSO REMEMBER THAT NATIONAL SAMPLING SURVEYS CAN OFTEN PROVIDE EXCELLENT AND RELIABLE INFORMATION, AND ALTHOUGH EXPENSIVE, MAY BE MUCH LESS COSTLY THAN A UNIVERSAL COUNT. FOR EXAMPLE, THE NATIONAL HEALTH INTERVIEW SURVEYS CONDUCTED BY THE NATIONAL CENTER FOR HEALTH STATISTICS ARE OF PRIME IMPORTANCE AND OFTEN PROVIDE DATA WHEN NO OTHER RESOURCE EXISTS. ALSO, WE HAVE BENEFITTED GREATLY IN ALABAMA FROM INFORMATION PROVIDED THROUGH THE KNOWLEDGE AND BELIEF SURVEYS FOR WHICH OUR STAFF WAS TRAINED BY CDC. OUR FINDINGS HAVE BEEN MOST HELPFUL IN HARD TO MEASURE AREAS SUCH AS HEALTH EDUCATION.

THE COMPATIBILITY OF STATE AND LOCAL DATA WITH THE YEAR 2000 OBJECTIVES WHEN VIEWED FROM THE HEALTH OUTCOME PERSPECTIVE RUNS THE GAMUT FROM AN UNEQUIVOCAL "YES" TO THE NEED TO RELY ON SURROGATE OR PROXY DATA. OBVIOUSLY, SOME OBJECTIVES ARE MEASURABLE BY VITAL EVENT DATA, SUCH AS THE INFANT MORTALITY RATE. OTHER OBJECTIVES REQUIRE AN ANALYSIS OF THE DATA PRIOR TO DRAWING A CONCLUSION REGARDING PROGRESS. I MUST REEMPHASIZE THE IMPORTANCE OF THE FLEXIBLE CLIMATE IN WHICH THE OBJECTIVES WERE DEVELOPED WITH A BASIS IN PRIORITY PUBLIC HEALTH NEED, RATHER THAN THE CONVENIENCE OF EXISTING AND DIRECT DATA SETS.

THE FINAL ISSUE I WAS ASKED TO ADDRESS RELATED TO THE ABILITY OF STATES TO ISSUE YEARLY "CHECK-UPS" USING NATIONAL DATA FOR COMPARISON. THE ANSWER TO THIS QUESTION WOULD DEPEND ON THE TECHNIQUE OF MEASUREMENT USED AND WHEN DURING THE YEAR REPORTS WOULD BE DUE. FOR EXAMPLE, TO DETERMINE THE INCREASE IN THE PERCENTAGE OF PERSONS USING FOOD LABELS TO MAKE SELECTIONS ON A NATIONAL SAMPLE SURVEY COMPARED TO A SAMPLE SURVEY IN EACH OF THE INDIVIDUAL STATES MIGHT BE FAIRLY EASILY OBTAINED, IF SOMEWHAT EXPENSIVE. IN OTHER AREAS SUCH AS THE REDUCTION OF HOMICIDES, THE NATIONAL DATA IS A COMPILATION OF STATE DATA AND, OBVIOUSLY NATIONAL DATA LAGS BEHIND DUE TO TIME NEEDED FOR PREPARATION AND SUBMISSION OF ACCURATE REPORTS AT THE STATE LEVEL. CONSEQUENTLY, A FORMAT WHICH ALLOWED FOR REASONABLE TIME FRAMES FOR THE REPORTING PROCESS WOULD BE IMPORTANT. ONE MECHANISM THROUGH WHICH STATES ARE ABLE TO REPORT ON UNIFORM ACTIVITY IS THROUGH THE

PUBLIC HEALTH FOUNDATION. AGAIN, THE NATIONAL HEALTH INTERVIEW SURVEY REFLECTS THE NATIONAL PICTURE FOR MANY OF THE OBJECTIVES.

THIS ENDS MY RESPONSE TO THE PREPARED QUESTIONS. IN CONCLUSION, I WOULD LIKE YOU TO CONSIDER THE FOLLOWING POINTS IN YOUR DELIBERATIONS REGARDING THE HEALTH OBJECTIVES INITIATIVES.

- THE PUBLIC HEALTH COMMUNITY SUPPORTS THE CONCEPT THAT ACCOUNTABILITY MUST BE A COMPONENT OF THE SERVICE DELIVERY SYSTEM. AS GOOD STEWARDS OF THE TAXPAYER'S DOLLAR, WE ARE COMMITTED TO IMPROVING OUR CAPABILITY IN THIS AREA.

- THE TECHNOLOGY OF THE INFORMATION AGE HAS VASTLY IMPROVED OUR ABILITY TO COLLECT AND ANALYZE DATA, BUT BEGS THAT WE EXERCISE PRUDENT JUDGEMENT IN OUR DEFINITION OF DATA NEEDS, SO THAT EACH LEVEL OF MANAGEMENT, LOCAL, STATE, AND FEDERAL HAS THE INFORMATION NEEDED TO MAKE INTELLIGENT DECISIONS WITHOUT HAVING COLLECTED EXPENSIVE BUT SUPERFLUOUS INFORMATION.

- THE RELIABILITY OF DATA GENERATED AT THE LOCAL LEVEL IS DIRECTLY PROPORTIONAL TO THE WORTH OF INFORMATION RETURNED THROUGH THE FEEDBACK LOOP AND ITS USEFULNESS FOR DAY TO DAY PROGRAM MANAGEMENT BY LOCAL STAFF.

- THERE WILL PROBABLY ALWAYS BE "CUTTING EDGE" PROBLEMS IN PUBLIC HEALTH FOR WHICH NO BASELINE DATA ARE AVAILABLE, CONSEQUENTLY, THE DEVELOPMENT OF DATA SETS IS AN EVOLUTIONARY PROCESS.

- SOME IMPORTANT OBJECTIVES WILL ONLY BE MEASURABLE BY SURROGATE DATA WITH THE COROLLARY ESTABLISHED BY STUDIES IN THE PUBLIC HEALTH BODY OF KNOWLEDGE.

- THE DEVELOPMENT OF DATA SETS, WHERE THEY ARE NEEDED, MUST RECOGNIZE A VARIETY OF DATA COLLECTION AND ANALYSIS TECHNIQUES AND SHOULD USE THAT TECHNIQUE FOR EACH OBJECTIVE WHICH PROVIDES THE MOST VALID AND RELIABLE DATA AT THE LEAST COST.

- THE FEDERAL INVESTMENT IN DATA COLLECTION EFFORTS SUCH AS THOSE OPERATING THROUGH THE NATIONAL CENTER FOR HEALTH STATISTICS SHOULD BE CONTINUED AS THEY ARE A CRITICAL COMPONENT OF THE INFORMATION NETWORK.

- THE ESTABLISHMENT OF HEALTH OBJECTIVES FOR THE NATION IS MOST USEFUL AS A BLUEPRINT FOR PREVENTIVE HEALTH ACTIVITIES WHICH HELPS TO CRYSTALLIZE CERTAIN PRIORITY AREAS AND ALLOWS FOR STATE TO STATE COMPARISONS.

- EACH OF THE STATES HAS UNIQUE CHARACTERISTICS AND CAPABILITIES WHICH MUST NOT BE IGNORED AS ANY NATIONAL EFFORT IS UNDERTAKEN.

- AND FINALLY, AS WE MOVE RAPIDLY TOWARD THE UNVEILING OF THE YEAR 2000 OBJECTIVES, THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS AND THE PUBLIC HEALTH COMMUNITY SUBMIT TO YOU THAT REGARDLESS OF THE QUALITY OF THE WRITTEN DOCUMENT, THE STATES' ABILITIES TO MOUNT AGGRESSIVE CAMPAIGNS TO ACHIEVE THE OBJECTIVES WILL REQUIRE ADDITIONAL RESOURCES. I WOULD REFER YOU TO SENATE BILL 2056, INTRODUCED BY SENATOR TOM HARKIN AND CO-SPONSORED BY A NUMBER OF SENATORS INCLUDING YOUR OWN SENATOR BINGAMAN, WHICH WOULD PROVIDE DOLLARS TO THE STATES TO ALLOW FOR NEW AND EXPANDED SERVICES DIRECTLY RELATED TO THE YEAR 2000 OBJECTIVES, INCLUDING THOSE OBJECTIVES RELATED TO IMPROVED DATA SYSTEMS. YOU SHOULD KNOW THAT OF THE $540 BILLION SPENT IN THIS COUNTRY ANNUALLY ON HEALTH CARE, LESS THAN $2 BILLION IS SPENT IN PREVENTIVE HEALTH SERVICES. THE TRAGEDY OF THIS STATEMENT LIES IN THE FACT THAT FOR EVERY DOLLAR SPENT IN PREVENTIVE SERVICES WE ARE ABLE TO FAVORABLY IMPACT ON THE OVERALL EXPENDITURE OF HEALTH DOLLARS. I ASK THAT YOU STUDY THIS BILL AND WORK FOR ITS PASSAGE FOR ECONOMIC AS WELL AS HEALTH REASONS. WITH THESE ADDITIONAL RESOURCES, AND FUNDS WHICH WE ARE ABLE TO GENERATE FROM OTHER SOURCES, I FEEL THAT SIGNIFICANT PROGRESS CAN BE ACHIEVED DURING THE NEXT DECADE, BOTH IN SERVICE DELIVERY AND IN OUR ABILITY TO DOCUMENT FOR YOU THE ASSURANCE THAT OUR ACTIVITIES ARE INDEED ENHANCING THE QUALITY OF LIFE FOR AMERICANS.

THANK YOU FOR ALLOWING ME TO COME HERE TODAY. I WILL BE HAPPY TO ANSWER YOUR QUESTIONS.

STATEMENT OF SENATOR TOM HARKIN
TO GOVERNMENTAL AFFAIRS SUBCOMMITTEE ON GOVERNMENT INFORMATION AND REGULATION

YEAR 2000 OBJECTIVES FOR THE NATION

Mr. Chairman, I want to commend you and the other members of the Subcommittee for your commitment and concern for the health of Americans. I, too, share your staunch support for the promotion of health and the prevention of disease.

Each year more than 1 million Americans die as a result of strokes, diabetes, cancer, coronary heart disease, chronic obstructive pulmonary disease, and cirrhosis. Many of these deaths are preventable. We know that people make lifestyle choices, such as whether or not to smoke and what they eat and drink. They may choose to engage in behaviors that place them at risk for disease, disability, and/or untimely death.

Far too many Americans, especially young people, die or experience disabilities as a result of traumatic injury caused by vehicular accidents and work related injuries. Injuries are the most common cause of death for children ages one to fourteen. We have it in our power to prevent this tragedy.

I believe that Americans want to be healthy. We try to be healthy. We keep an eye on our cholesterol levels, we exercise regularly, and pay attention to our diets. As a nation, we are acutely aware of the need for a healthy workforce, in order to maintain our competitive stance in a world market.

Thus, I am pleased to be the author of S.2056, the Health Objectives 2000 Act. I am pleased that you have joined with me on this bill, Senator Bingaman, along with the Chairman of the Labor and Human Resources Committee - Senator Kennedy; the Ranking Member - Senator Hatch; Senator Pell who is a lifelong advocate of health promotion and 21 others.

The Health Objectives 2000 Act is an all out effort to implement the nation's Health Objectives for the Year 2000, an issue of great concern to this Committee. My colleagues and I are calling for a renewed national effort to prevent the most common and costly causes of disease, disability and death.

This legislation will help Americans stay healthier and it will save money as well. Americans spend more than $680 billion each year on health care. If more efforts to promote health and prevent disease and disability can result in even a 1% reduction that means we can save more than 6.8 billion each year.

Again, I want to thank you for the opportunity to speak before you today and for your assistance and support as we all strive toward a healthier America.

AMERICAN PUBLIC HEALTH ASSOCIATION
1015 Fifteenth Street, N.W., Washington, D.C. 20005 • (202) 789-5600
WILLIAM H. McBEATH, M.D., M.P.H., Executive Director

April 23, 1990

The Honorable Jeff Bingaman
Chairman
Senate Governmental Affairs
Subcommittee on Government Information
US Senate, 605 SHOB
Washington, D.C. 20510

Dear Chairman Bingaman:

It has come to our attention that the Senate Committee on Governmental Affairs Subcommittee on Government Information recently held a hearing on national health statistics. During the committee deliberations, it is our understanding that the national Health Objectives for the Year 2000 were discussed.

The American Public Health Association (APHA) is an organization of public health workers with a national and affiliate membership of over 50,000. We are vitally interested in the Year 2000 Objectives, and have been actively and continuously involved in their development. We are members of the Year 2000 Consortium, and are developing the companion publication to be used to implement the Objectives in state and local public health agencies, the *Model Standards: a Guide for Community Preventive Health Services, Third Edition.*

It is our perception that you would like to see a short list of quantifiable objectives which can be used as a national "report card" on health. APHA shares that desire. Our Executive Board is quite concerned that the sheer number of different objectives in the draft document released last September may obscure and diffuse the major health needs which were identified. We have urged that a small list of easily-understood objectives be promulgated, which would call attention to the major priority areas the objectives represent.

I am enclosing our comments on the draft objectives for your information. They expand on our concerns about the structure and content of the objectives now under revision. APHA would appreciate it if you would include the comments in the record for the hearing noted above.

Very truly yours,

William H. McBeath

William H. McBeath, MD, MPH
Executive Director

Enclosure

cc: Bob Moore

COMMENTS
ON
THE YEAR 2000
HEALTH OBJECTIVES

SUBMITTED BY:

THE
AMERICAN PUBLIC HEALTH ASSOCIATION

NOVEMBER 15, 1989

EXECUTIVE SUMMARY

APHA COMMENTS ON THE YEAR 2000 OBJECTIVES

The draft Year 2000 Objectives performed best in their technical detail, less well in the area of identifying the most important objectives for the country, and poorly in their unjustified and unexplained exclusion of major health risk factors from consideration.

APHA supports the idea of a three-level, hierarchical set of Objectives. The first level would be overall goals of the National Health Objectives: reducing occurrence of preventable morbidity and mortality, reducing preventable disability, and closing the gaps in health status among different, identified groups in our population.

The second level in the hierarchy would be a short list of fifteen to twenty specific health status objectives. Included in this list would be sentinel causes of morbidity and mortality in different groups in our population, e.g., infant mortality. Socioeconomic status (SES) and its effect on health must be dealt with directly in these overarching health objectives

The third level would be the national health status, disease control and risk reduction targets, published separately for those actually concerned with the specifics of program implementation. These must be comprehensive and must include a mechanism for prioritizing program objectives in different places and among different groups.

APHA recommends the addition of priority areas and objectives to assure that the *Model Standards* accurately reflects a complete collection of activities from which states and localities can select priority items for attention in their jurisdictions. As the Objectives are revised, APHA would welcome continued close collaboration between the Office of Disease Prevention and Health Promotion and the Model Standards Project so that the two important documents agree.

APHA urges the use of the World Health Organization (WHO) definition of health as the basis for the Year 2000 Health Objectives.

The draft Objectives should give more attention to important public health problems such as:

1. Socioeconomic factors influencing health
2. Family planning, including abortion services
3. Risks to children, particularly violence, special needs and multiple risk children
4. Violence per se
5. Environmental interventions, especially as they apply to prevention of trauma and as they broadly affect health status
6. Environmental issues such as water and air pollution

The most important omission from the draft objectives is **socioeconomic status and the effect of poverty on health.** Therefore, additional risk reduction objectives are essential for the achievement of year 2000 health status objectives, including a national health program, adequate housing, full employment, and an end to poverty. As one of our reviewers put it:

> There needs to be more activity focusing on meeting other human and social service needs especially in the low income, under-served populations. Preventive and health education services will not be a priority for those whose basic need for food, clothing and shelter are not met.

There should be a **separate priority area for child health** with a special emphasis on reducing the number of children at high risk because of early sexual activity and childbearing, educational failure, drug use or delinquency. Virtually all of the specific preventive services which should be targeted to low-SES children could be delivered with the adoption of two major policies: **a national health program** and **a uniform upgrading of environmental preventive services** available at the local level.

Environmental precursors of violent behavior and the risk factors which increase the severity of violence need to be dealt with. Objectives should strive to change societal attitudes towards violence, and protect people from lethal violence, e.g., by reducing the acceptability of violent portrayals in the media and reducing the prevalence of handguns.

APHA recommends including **more specific environmental interventions** in the risk reduction objectives. These include housing standards, food protection, materials standards, legislation, energy conservation standards, solid waste management, and air pollution control to prevent deaths and injuries from emission of harmful materials into the air. We deplore the excessive concentration of objectives on individual behaviors, which tends to be victim-blaming and distracts attention from the need community action.

Omission of a goal for lung cancer -- the nation's most common malignant tumor today -- seems indefensible, as does lack of a target for atherosclerotic heart disease and for chronic lung disease. APHA supports the establishment of **priorities for chronic disease control.**

APHA recognizes the importance of involvement of the broadest constituency at every level if sought-after improvements in health are to be realized. We support the efforts of the Office of Disease Prevention and Health Promotion (ODPHP) to develop true grassroots planning and ownership of the process and its goals.

COMMENTS OF THE AMERICAN PUBLIC HEALTH ASSOCIATION ON THE DRAFT YEAR 2000 HEALTH OBJECTIVES FOR THE NATION

Introduction

The American Public Health Association (APHA), an organization of public health workers with a national and affiliate membership of about 50,000, is pleased to submit its comments on the draft *Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation*. APHA recognizes the monumental effort of the many individuals who drafted, reviewed and compiled this document. Many of our members were among them.

APHA has long supported the concept of national health objectives and has participated actively in the development of these draft goals. For review and comment on this draft, we obtained input from the Association's component groups: sections, affiliates and special primary interest groups (SPIGs), which has been used in developing the position stated below. APHA's sections are groups of public health professionals organized by professional discipline and program interest area (e.g., Epidemiology, Public Health Nursing, etc.). Affiliates are state-level organizations of public health workers. SPIGs are nascent sections, consisting of smaller groups of people who join together under a common professional focus.

At its April 24-25, 1989 meeting, APHA's Executive Board reiterated APHA's commitment to the development and implementation of the best possible public health objectives. However, on learning that there were some 800 first draft objectives, and that there might be as many as 400 in the public comment draft, APHA's leadership became concerned that the importance of these objectives to the health and well being of our nation might be lost in their detail. It then requested that the comments developed behalf of APHA strive to "make the objectives manageable [in number and complexity]". In its action, the Board stated:

> It is our impression that the materials we are getting [with respect to the Year 2000 Objectives] are getting so detailed that the cogency of a limited number of measurable objectives is losing its strength by being drowned in the flood of materials coming forth.

APHA's comments on the draft objectives are presented below. These comments were developed by APHA's Program Development Board Subcommittee on the Year 2000 Objectives after it received comments from 16 sections and 7 affiliates.

APHA's review of the draft Year 2000 Objectives is presented in three parts. The first presents APHA's views on the **structure** of the Year 2000 Objectives including recommendations for broad, overarching objectives referred to in the draft as "goals". The second discusses gaps in the draft document. The third summarizes the comments of APHA sections and affiliates on the objectives as they were presented to us. Generally speaking, APHA believes that the draft objectives performed best in their technical detail, less well in the area of identifying the most important objectives for the country, and poorly in their unjustified and unexplained exclusion of major health risk factors from consideration.

Structure of the Objectives and Goals

APHA believes that the Objectives as written are a worthy effort, but are mislabeled. Many of them can really be viewed as program steps within a much broader health objective. For example, if a broad health objective were healthy adolescents and the outcome indicators were injury deaths and disability days, then one program step might be to increase the average age of first use of alcohol as stated in draft objective 4.6. Since public health workers will need detail in order to achieve broad health objectives, there is much good to be said for the entire document as presented. As a program planning document it will be particularly useful for devising state and local plans to deal with broader objectives.

As proposed in the introductory section, "Goals for the Nation", APHA agrees with the Office of Disease Prevention and Health Promotion (ODPHP) in its intention to state broad health goals for the country. However, for clarity these broad goals should themselves be referred to as "the National Health Objectives for the Year 2000" once they are adopted. The longer document, currently called Objectives, can be relabeled to identify it as national health status, disease control and risk reduction targets, necessary for achieving the National Objectives. A several hundred page document is clearly inappropriate for marketing the Objectives to a broad audience, but will be needed to capture details which professionals will use to steer programs. Having heard the arguments presented at the Consortium on the Year 2000 Objectives and its members' concerns, APHA supports the idea of a three-level, hierarchial set of Objectives.

The first level is not quantitative, in that it sets forth the very broad purposes we hope to achieve. Dr. Edyth Schoenrich stated those goals as:

1. To reduce occurrence of preventable morbidity and mortality
2. To reduce preventable disability
3. To close the gaps in health status among different, identified groups in our population

The second level in the hierarchy would be a short list of fifteen to twenty specific health status objectives which we would like to achieve. These would be chosen to represent the complete list of health status objectives which would be a part of the third level. They would be readily identifiable and understandable as health problems by the health professionals, community leaders at all levels, and the general public, and would highlight needed achievements related to each of the goals. In particular, socioeconomic status (SES) and its effect on health must be dealt with directly in the overarching health objectives. APHA's recommendations for inclusion on the short list are:

1. Infant mortality
2. Morbidity from misuse of drugs*

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* "Drugs" here includes alcohol. Morbidity can be measured by health interview surveys or by emergency department surveillance.

3. Unintentional injuries among children and young adults
4. HIV infections
5. Unintended pregnancies among teenagers
6. Coronary artery disease mortality before age 65
7. Lung cancer deaths in women
8. Cirrhosis mortality
9. Mobility impairment in persons over 65
10. Homicide and suicide mortality

As noted above, these short list items should include emphasis on closing gaps between rich and poor either through subobjectives or through setting a target that is sufficiently ambitious that achievement will only occur through disproportionate improvements in the status of the most vulnerable group.

The third level would be the national health status, disease control and risk reduction targets. These targets will, in turn, be the major reference for persons and groups actually developing strategies designed to impact on the overall health. objectives. They must, therefore, be comprehensive (a goal of ODPHP which was not achieved in this draft). The need to achieve specific program objectives will vary from place to place and group to group, so that a mechanism for prioritizing program objectives (also missing from the draft document) will be needed.

The organization of the third level of objectives is important. Since it will be intended to be an encyclopedic resource, it should have numerous cross references. For economy, repeating objectives in multiple locations can be eliminated provided the structure is reasonable and cross references are included. APHA is particularly supportive of the idea of cross tabulation of health status objectives against the pertinent risk reduction and disease control objectives. We also think a table of objectives pertinent to major demographic groups (e.g., age ranges) would be helpful.

The *Model Standards*, of course, is the appropriate vehicle for designing specific community programs to meet larger health objectives. As a community implementation workbook, it is also a critical element to reaching the year 2000 objectives because their accomplishment largely depends on the degree to which communities use and adopt them. The success of the next edition of *Model Standards* depends on the existence of complementary national targets for each of the program steps needed to reach our national health goals. Unfortunately, the draft Objectives are not complete, as many major areas have been omitted entirely or dealt with superficially. APHA recommends the addition of priority areas and objectives as described in the next section to assure that the *Model Standards* accurately reflects a complete collection of activities from which states and localities can select priority items for attention in their jurisdictions.

Gaps in the Objectives

One key omission from the draft Objectives is a definition of health. Implicit in the title of the draft is a broad definition: if "promoting health" were merely a synonym for "preventing disease", the title could be shortened with no loss of meaning. In "Goals for the Nation", the writers discuss improving "health *and* well being", and go on to speak of "improving the quality, not just the quantity of life." The inclusion of objectives on mental and behavioral disorders as well as violent and abusive behavior strongly suggests a health definition that is inclusive of social well being, not exclusively medical in its scope.

APHA urges the use of the World Health Organization (WHO) definition of health as the basis for the Year 2000 Health Objectives. We believe it is consistent with the intent of the drafters of the document and is appropriate public health policy. As stated in the WHO constitution, health is "...a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." However, to achieve the absence of disease will require attention to the social environment, to the physical environment and to mental health issues considerably beyond what appears in the draft Objectives.

The draft Objectives give insufficient or no attention to important public health problems in the risk reduction and disease control objectives. Also, there are significant omissions from the health status objectives.

Risk reduction and disease control objectives deal inadequately with:

1. Socioeconomic factors influencing health
2. Family planning, including abortion services
3. Risks to children, particularly violence, special needs and multiple risk children
4. Violence per se
5. Environmental interventions, especially as they apply to prevention of trauma and as they broadly affect health status
6. Environmental issues such as water and air pollution

We have also noted important omissions from the list of health status objectives. The most important omission from the draft objectives is socioeconomic status and the effect of poverty on health. It is commendable that the drafters of the objectives implicitly recognized that SES is more important than other demographic markers such as race in determining risk of many adverse health outcomes. For example, there are special population targets for low income people in the objectives for Nutrition, Physical Activity and Fitness, Tobacco, Vitality and Independence of Older People, Environmental Health, Maternal and Infant Health, High Blood Cholesterol and High Blood Pressure, Cancer, Other Chronic Diseases, Oral Health, and Health Education and Preventive Services. Unfortunately, there are many more special targets for racial and ethnic groups, perpetuating the myth that it's what color your skin is and not how economically advantaged you are that determines health status.

What's worse, the special targets for low income groups are often substantially lower than for the general population. The overwhelming evidence is that low income people have more risk factors and worse mortality and morbidity experience than the general population. Since preventive services are effective in reducing that risk, then we should provide the resources to achieve parity in health status between low income and general populations instead of accepting lower targets for service delivery (20.1). In the area of behavioral change, why assume poor people can't improve as much as affluent ones? Some may construe the current approach as victim-blaming. By setting up different goals for poor people, we are saying as a nation that observed differences in health status due to SES are acceptable.

APHA is concerned about the failure to address poverty as a risk factor for disease. There is a substantial body of literature which shows the importance of adequate living standards on good health. Most experts believe that the decline in incidence of many infectious diseases in the developed world is linked most directly to improved standard of living. In that regard, it is not surprising that the poorest people in America today -- the homeless -- have rates of tuberculosis disease comparable to that found in third world countries. National and international studies (1,2,3) underscore the clear association between low SES and increased occurrence of most of the illnesses which these objectives seek to prevent. The environment in which poor people live is more polluted, has more crime, worse educational opportunities, lower quality housing, less availability of preventive services, and more available drugs and alcohol than more affluent areas. The result of that environment is hopelessness, helplessness and underachievement.

Although the draft objectives contain many risk reduction and disease control measures such as smoking, seat belt use and obesity, we are concerned about the failure to address poverty as a risk factor for disease. There should be risk status measures of socioeconomic variables such as poverty level, employment status, educational achievement, and housing. There is also, regrettably, no commitment to assuring access to preventive services for all people. Poor children, who are at highest risk because of their SES, should have the easiest access to the basic preventive services which might help mitigate the health consequences of poverty.

APHA feels that the following risk reduction objectives are essential for the achievement of year 2000 health status objectives:

- **National Health Program.** By the year 2000, a basic program of preventive and curative health services will be guaranteed to every U.S. citizen without regard to employment, health status or ability to pay.
- **Housing.** By the year 2000, no U.S. citizen will be involuntarily homeless because of lack of personal income or lack of available housing of acceptable quality.
- **Full employment.** By the year 2000, every U.S. adult below the age of retirement who is capable of working will have a productive job.
- **End poverty.** By the year 2000, every U.S. family will have income which exceeds the poverty level for a family of its size and composition adjusted for the cost of living in the family's place of residence.

In the area of **family planning**, APHA is concerned that the developers of the draft Objectives missed the point altogether. Therefore, the connection between family planning services and healthy infants, mothers, and families, which has been clearly established in research, has been ignored. Nor is there any hint of any policy towards population. There is also a totally unwarranted focusing on teenage sexual behavior, and an emphasis on prevention of first intercourse, even though unintended pregnancy can occur at any age and family planning services are needed throughout the reproductive years. While there is a healthy emphasis on sex education, the tone of the remainder of the material in the priority area on sexual behavior makes one wonder just what the content of "school-based family life and sex education" offered under 5.16 might be.

APHA recommends that the national health objectives contain:

- o An explicit **goal for population growth.**

- o A specific objective of **reducing unintended pregnancy** by 35 percent.

- o An objective based on the principle "every child a wanted child" which seeks to **minimize unwanted fertility.**

  In the absence of perfect contraception reliably used, this implies availability of abortion services. APHA acknowledges the politically devisive nature of such a statement, but we feel, on balance, that the health consequences of unintended childbearing on both mother and child continue to require the ready availability of this choice.

- o In the Federal implementation steps for these objectives should be a commitment to **development of improved contraception** and contragestion technology, which could obviate the need for significant numbers of abortions as well as improve the health of contraceptive users.

  The Federal Government must use its considerable power to develop and promote new, safer, more effective contraceptives. Method failure, user failure, and fear of side effects, actual side effects are responsible for too many unplanned pregnancies.

Data are available or attainable to measure the achievement of each proposed objective. Only the last one is not a health status objective.

With regard to **risks to children**, APHA questions the structure of the draft objectives. Infants and older people get special attention, but the population aged 1 through 18 is often ignored. Children should be a priority area, and, as others have already suggested, one objective should be reduction in the prevalence of high risk children, defined by Joy Dryfoos (4) as those who are engaged in early sexual activity and childbearing, are educational failures or dropouts, are regular drug users, or are delinquent. There is a substantial body of evidence that such high risk, disaffiliated youth become problem adults. Violent behavior, criminality, substance abuse, child abuse, and general ill health are their lot in the absence of targeted interventions designed to reduce a vulnerable child's risk status. Although a portion of this concern is recognized in the proposed Mental and Behavioral Disorders objectives (19.7-19.9), this constellation of risk factors should be identified as a major precursor of poor health outcomes in children and included within a priority area which focuses on child health.

Also included in objectives for protecting children should be well child care, especially the immunizations and preventive services outlined in the U.S. Preventive Services Task Force report. These are process objectives and should perhaps be relegated to implementation plans. Access to services is an especially critical issue for those in vulnerable states of development. Preventive services (social, educational and medical) are needed to cushion some youth against the effects of failed families.

Numerous services and protection objectives need to be strengthened to assure access to services for low SES children. In nutrition, the change to school lunches needs to be coupled with continued subsidy of school lunches for poor children (1.19) and the more nutritious brand items need to be priced competitively with current items and available in stores where poor people shop (1.21-1.22). Physical activity through schools (2.11 and 2.12) and community organizations (2.14) needs to be at least as available to those of low SES as the general population. Tobacco use cessation programs need to be especially targeted to low-income people. Alcohol advertising to low income neighborhoods should be curtailed. Family planning services (including abortion) should be convenient and financially available to low income persons and sex education should be targeted to the most at-risk groups (5.16). Physical and mental diagnosis treatment for abused children (6.18) needs to be accessible to them. Violence prevention programs (6.19) should be targeted at populations where violence is particularly prevalent.

Mitigation of environmental hazards in low-SES neighborhoods (such as automotive and industrial emissions, lead abatement, housing stock maintenance, and vector control) should be assured. Occupational health preventive programs (e.g., 9.24 and 9.25) should be at least as available to the lowest-income workers as to the highest. Access to emergency medical treatment for trauma should be assured for low-income people, especially children. Special immunization targets (12.13) for low-income children and services designed to reach them should be in place to eliminate preventible epidemics such as the measles in southern California and Chicago. Treatment of HIV-infected children and sex and drug education should be concentrated in low-SES populations because of the higher infection rates found there. Sexually transmitted disease diagnosis, treatment and followup services should be assured for poor people. Screening for amblyopia and hearing impairment (17.23 and 17.24) and treatment for these disorders should be accessible to low income children and financing should be assured. Dental preventive services (18.19 and 18.21) need to be available to low income children. Those general preventive services recommended for all children should be assured for low income children (20.20), and community health education programs should be at least as prevalent in hospitals that serve low-SES populations as other hospitals.

Virtually all of the specific preventive services which should be targeted to low-SES children could be delivered with the adoption of two major policies: a national health program and a uniform upgrading of environmental preventive services available at the local level.

Measurable objectives need to be developed which chart the health status of the nation's special needs children: those with physical or mental disabilities. The objectives should set achievable targets for functional improvement and independence parallel to those established for elderly Americans in the draft objectives.

Violence per se is an emerging public health issue which has impact at all levels, from interpersonal to international. APHA commends the drafters of the Objectives for dealing with the question of violent and abusive behavior. However, we believe that the environmental precursors of violent behavior and the risk factors which increase the severity of violence need to be dealt with. Objectives should strive to change societal attitudes towards violence, and strive to protect people from lethal violence. Thus, reducing the acceptability of violent portrayals in the media might be one outcome objective, and measuring and reducing the prevalence of handguns might be another.

The draft Objectives are overly reliant on clinical and individual treatments, often overlooking the superior efficacy of appropriate **environmental interventions** as steps to achieve desired outcomes. Such proved measures include: housing standards, which protect against fire death, overcrowding, injury in the home, and natural disasters; food supplementation; materials standards, e.g., for plumbing, paints and food containers to protect against lead poisoning; legislation, e.g., to protect against tobacco advertising and sales to minors; energy conservation standards to protect against air pollution and the health consequences of global warming; solid waste management and recycling to reduce the amount of harmful materials in the environment and the nuisances produced by their long term storage or disposal; and air pollution control to prevent deaths and injuries from emission of harmful materials into the air. These are but a few examples of environmental interventions which APHA supports, but which are not dealt with in the Objectives. One additional potential intervention has already been stated: gun control, a measure with demonstrated efficacy in reducing the death toll of interpersonal violence.

Although environmental interventions are by definition not health outcomes, neither are personal health measures such as immunization. Achieving appropriate levels of both have demonstrable impact on the population's health, however, and APHA recommends including more specific environmental interventions in the risk reduction objectives.

Finally, APHA is puzzled that major causes of death and disability in the United States do not appear as identifiable outcomes in the draft Objectives. Omission of a goal for lung cancer -- the nation's most common malignant tumor today -- seems indefensible, as does lack of a target for atherosclerotic heart disease and for chronic lung disease. APHA supports the establishment of priorities for chronic disease control. The draft Objectives miss that target by a wide margin.

Comments on Individual Priority Areas

Comments elicited from APHA reviewers on the individual priority areas are summarized below. An additional area has been added to capture global comments on the Objectives which were received.

1. Nutrition

APHA's reviewers gave the highest priority to objectives which they believed influence cardiovascular disease mortality. The most important objective was 1.8, intended to reduce dietary fat intake. Reviewers also favored reducing prevalence of overweight, increasing knowledge of dietary risks, and increasing consumer choices in lower fat, lower sodium items. Growth retardation, while an important outcome, probably received less attention because of its relative infrequency in the general U.S. population and because U.S. children with this condition often have medical or social problems which can (and should) be directly addressed. There were a number of technical comments, many of which suggested that the goals were too modest.

2. Physical Activity and Fitness

The first objective in this group (prevalence of moderate physical activity in adults) was generally felt to be critical. Several reviewers emphasized the importance of objective 2.11 (physical education in schools). Objectives 2.2, 2.3 and 2.9 were felt to overlap 2.1 and to be of lesser importance; 2.8 and 2.12 were also considered candidates for deletion because they were too detailed and not quantifiable, respectively. There was considerable enthusiasm for a worksite exercise objective (2.13).

3. Tobacco

APHA reviewers were generally pleased with the amount of effort given to control of tobacco use. The first objective in the area (3.1) was widely believed to be appropriate and achievable. There was less universal support for the prevention of initiation because of its overlap with age-specific prevalence goals and because of concerns about the accuracy of measuring techniques among some members. Prevention of tobacco use through school curricula (3.8) was also supported. Less emphasis was placed on smokeless tobacco and tobacco use during pregnancy, probably because members felt that reducing overall prevalence would also reach these special groups. Workplace and other restrictions were universally favored. It was suggested that a special population target be small businesses.

Advertising restriction (3.13) was believed unenforceable as proposed; a suggested alternative was to increase the amount of anti-smoking propaganda. A national objective on tobacco control should speak to elimination of all tobacco promotion, as there is ample evidence of the efficacy of advertising in luring young people to addiction and death. An additional objective was suggested: ending all Federal subsidies to the tobacco industry.

APHA reviewers expressed disappointment with the focus on state legislation, when there is a clear and effective role for Federal (airline restrictions) and local (public smoking restrictions) laws in controlling smoking. They also thought that target groups for tobacco use prevention should generally be younger than proposed in the draft Objectives.

4. Alcohol and Other Drugs

Numerous reviewers addressed these issues. Several strengthening additions to the wording of objectives were offered. Reducing alcohol-related crash deaths (4.1) vied with reduction of use among young people (4.7) as the most important objective. One person suggested that 4.6-4.8 had considerable overlap and could be combined. Protecting fetuses from exposure to drugs of all kinds was also supported widely. It was noted that 4.2-4.4 and 4.6, 4.8, and 4.9 were of lesser importance and could potentially be eliminated, since achievement of the other objectives would probably satisfy them as well.

The worksite objective (4.17) received heavy criticism: it is neither quantifiable nor measurable as stated, nor are there baseline data. It should be eliminated. (It is not entirely clear just what a "drug free workplace" means. In the event it contains a program of mandatory urine drug testing, APHA would be particularly opposed to it.)

Finally, there was a singular lack of enthusiasm among APHA's reviewers for the Services and Protection and Professional Education and Awareness portions of these objectives. Many were felt to be nonquantifiable, or just less important than others mentioned above.

5. Sexual Behavior

The sexual behavior objectives drew much thoughtful comment and criticism. Although these comments have been expanded under "Gaps", it is important to state both the depth of the concern and the consistency with APHA policies and good public health practice which these objections and suggested additions identify.

APHA would support both a change in name for this priority area and a change in emphasis. The new name should be "Sexual Behavior and Family Planning". Limiting the discussion of sexual behavior to teenage pregnancy and sexually transmitted disease is not appropriate. Unintended pregnancies occur at all ages and are preventable at all ages. These objectives should include:

- Universal access to family planning services;
- A goal of reducing the number of unintended births; and
- Increased knowledge of effective contraceptive methods.

APHA members do not object to most of the points currently addressed within the priority area, and support goals to reduce unintended teenage fertility (e.g., 5.1 and 5.2). They are not supportive of simplistic efforts to reduce the prevalence of sexual activity among older teens (5.6). They feel that young males should be special population targets in public awareness programs (e.g., 5.10 and 5.11).

6. Violent and Abusive Behavior

There was widespread support for the intent of these objectives. The goal of reducing homicide and suicide met approval; the targeted reductions were viewed as far too modest. APHA believes that a more appropriate goal for violent deaths is to reduce rates of morbid events (e.g., homicide) until they lie in the lowest quartile of national rates reported by other developed countries. The discussion of gaps has addressed the principal environmental problem which underlies the fatal outcome of many violent episodes -- widespread availability of handguns -- which is completely ignored here. Instead, vaguely defined violence prevention programs are proposed (6.19), which are more strategies than objectives anyway. One reviewer asked for the inclusion of an objective on the abolition of one specific kind of socially sanctioned violent behavior, corporal punishment in schools.

7. Vitality and Independence of Older People

Many people commented on these objectives. Our experts felt that the targets for active life expectancy and independence (7.1 and 7.2) were particularly worthy. The heavy overlap with other priority areas was noted, but little within-area overlap was identified. Suicide (7.4), physical activity (7.10 and 7.11), smoking (7.14) and the three Professional Education and Awareness objectives were perceived to have too modest a target. Questions were raised about whether objectives related to glaucoma (7.15), incontinence (7.9) and leave for care givers (7.21) were measurable.

The Alzheimer's Disease objective (7.22) was not supported because it was deemed not measurable due to underlying uncertainties about the underlying pathological process. One reviewer called for two additional objectives: increasing the supply of community-based long term care services and improving the quality of institutional settings.

8. Environmental Health

There were general concerns noted about the narrowness of scope of these objectives. Omissions include groundwater and food supply protection, solid wastes, the global environment, and environmental health planning. These are more thoroughly discussed under "Gaps", above. There were also general suggestions that these objectives should be more closely linked to occupational health objectives, because work may be a contamination source and environmental controls may influence worker injury rates.

A shortfall in the supply of adequately trained environmental health personnel was identified as one particular problem which would have to be addressed as a professional education and awareness objective (cf. 8.9).

Apart from identification of gaps, there is a divergence of opinion within APHA on priorities. Lead toxicity abatement and use of blood lead as an indicator (8.1 and 8.2) are regarded favorably. Some reviewers appear to have emphasized toxic waste cleanup (8.6) in response to exaggerated public fears.. Widespread, indiscriminate radon testing of homes is not well accepted by APHA's experts who note that presence or absence of tobacco smoke should be considered in deciding whether to do radon testing.

9. Occupational Safety and Health

APHA policy supports the development of smoke free workplaces as set forth in 9.19. Concerns were expressed about 9.22 (alcohol- and drug-free environment) which amplified what was said under Alcohol and Other Drugs. The idea of reducing workplace injuries and deaths (9.1 and 9.2) won approval. Although reviewers ranked proposed objectives differently after the first two, there was little movement to delete any of them.

10. Unintentional Injuries

There was a generally favorable response to the health status objectives in this priority area. However, one reviewer emphasized that these are public health objectives and should not contain terminology which is victim-blaming and ill-defined. Hence the use of the term "abuse" should be replace with "use", as in "alcohol and other drug use". There was some sentiment for removing 10.3, 10.4 and 10.5, presumably because the outcomes cited (falls, drowning and fires) occur much less frequently than crashes, and reducing alcohol-related motor vehicle deaths would probably affect the other rates. Belt laws (10.17), reduction of heavy drinking (10.10; overlaps with alcohol objectives), and head injury reduction (10.8) also were highly ranked. With the exception of improved emergency medical services, there was little enthusiasm generated for the other public awareness, services and protection and professional education objectives.

11. Maternal and Infant Health

This priority area is of critical importance. The relatively modest number of comments and the lack of intensity reflects APHA's general endorsement of strong objectives and their noncontroversial nature among this organization's membership. Provision of prenatal care (11.15), reductions in infant mortality rates (11.1 and 11.2), protection of fetuses from exposure to harmful drugs (11.12) and protection of mothers (11.5) were ranked in the top two objectives by one or more of APHA's reviewers. Some suggested eliminating intermediate objectives such as prevention of low birthweight (11.3), not because it is unimportant, but because it is so highly correlated with infant mortality. APHA's reviewers suggest that it would be possible to reduce the number of different indicators used to gauge maternal and infant health without sacrificing the overall goal of healthy mothers and infants.

12. Immunization and Infectious Diseases

The reviewers in APHA agreed that reduction of indigenous cases of vaccine-preventable disease (12.1) and achievement of adequate immunization levels (12.13) were the most important objectives in this priority area. Influenza (12.2), viral hepatitis (12.3), and tuberculosis (12.4) also were accorded high priority.

The reviewers expressed uncertainty about the measurability of a number of the draft Objectives, including the foodborne illness (12.7), infectious diarrhea (12.10), and food inspections (12.17) objectives. The middle ear infection objective (12.11) was low ranked, possibly because it is speculative as written. Reviewers presumed overlap of waterborne illness and food inspections with the Environmental Health priority area; however, these were significant omissions from the latter area.

There was little suggestion that there should be wholesale deletions from this priority area; comments were more directed to measurability and to implementation issues than to desirability. These objectives, which require substantial levels of individual service, sometimes in hard-to-reach populations, will be expensive to achieve.

13. HIV Infection

This one priority area attracted more comments than any other. As befits a controversial public health problem for which the best control measures are not completely established, there was no unanimity on priorities, or even over whether objectives were appropriate.

Most agreed that reduction in AIDS incidence (13.1) was measurable, and presumably all felt it to be desirable. However, one group faulted the proposed objective as too modest a goal, and one suggested eliminating an AIDS incidence target altogether, preferring infection prevalence and risk factor reduction. One reviewer suggested focusing most attention on professional and public education (13.10-13.12).

There was division within APHA between "absolutists", who felt that clean needles (13.7) and disinfection of equipment (13.13) was unacceptably tolerant of intravenous drug use, and "pragmatists", who favored these activities because you can't give drug abuse treatment to an addict dead from AIDS. APHA's policies support the more pragmatic position. APHA supports bleach distribution programs and needle hygiene education. We also support demonstration and evaluation of needle exchanges as a possible means of reducing HIV spread.

Reviewers suggested lowering the age at which HIV education begins in schools (e.g., to 5th grade; 13.12), and indicated a need for early HIV education in non-school settings. A special population target for condom use in minorities was proposed, recognizing the higher infection levels currently in these populations. Additional research would probably uncover a more fundamental SES relationship to risk, which should be used to define high risk targets.

The objectives for reducing infection levels in specific populations were uniformly supported: women giving birth (13.2), gay men (13.3), and intravenous drug users (IVDUs;13.4). Opinions differ as to which group of IVDUs should be sampled: a treatment entry group as proposed or an anonymously tested group.

Many of these objectives were noted either to lack baseline data entirely or to have unreliable baseline data. Some also had no clear plan for achievement, e.g., 13.1, 13.3, 13.4, 13.13, 13.14-13.17.

14. Sexually Transmitted Diseases

As with HIV control, there was some disagreement about whether the highest priority for objective setting should be a clinical outcome, e.g., incidence of syphilis (14.2) and gonorrhea (14.1) or should be risk factor control, e.g., condom sales (14.9), and epidemic management, e.g., partner notification (14.12). Most supported the former, with priorities 14.1-14.4 generally ranked highest.

There was a suggestion that chlamydia trachomatis infections should be reportable. There were also questions about the measurability of a treatment management objective (14.11), and about the content of counseling (14.6). APHA comments were generally supportive of most objectives in this area.

15. High Blood Cholesterol and High Blood Pressure

This priority area also provoked debate within APHA. The Program Development Board of APHA has endorsed the report of the U.S. Preventive Services Task Force (the *Guide to Clinical Preventive Services)* when used as intended. A formal APHA endorsement is likely in a few months. That report sets a more conservative tone than might be implied by objectives 15.15, 15.17, and 15.21.

The principal internal disagreement among APHA's reviewers was whether to target risk reduction ahead of clinical outcome. Ranking of outcomes and risk factors, however, made it clear that APHA's membership is more convinced of the value of blood pressure control than of cholesterol intervention. Furthermore, the focus on drug therapy for elevated cholesterol in 15.21 was questioned, as such therapy may produce numerous side effects.

Several objectives were candidates for combining: 15.4 and 15.5 15.19 and 15.20; 15.16 and 15.17; and 15.22 and 15.23. APHA believes it is feasible to combine some of the more correlated objectives in this priority area. As an alternative, outright deletion of some objectives is suggested by one reviewer, who proposes elimination of 15.10,15.11,15.14-15.18 and 15.24 (most of us would disagree with the last proposed deletion which relates to laboratory quality control unless cholesterol screening is abandoned outright).

16. Cancer

Although APHA's reviewers accepted many of the priority area's objectives, there were numerous concerns about omissions. Perhaps the inclusion of tobacco objectives (16.4 and 16.5) is intended to address this. Everybody knows that smoking causes lung cancer; but to omit the most common tumor from specific outcome objective setting just doesn't make sense to our membership. We also wonder why an objective for other very common sites of cancer -- prostate and skin -- weren't included.

We note that there is conflict between objective 16.13 and the *Guide to Clinical Preventive Services* recommendations for colorectal cancer screening. This objective received a low ranking by our experts and could probably be eliminated. Dietary and environmental interventions are more likely to be effective than proctoscopy for prevention of that tumor. Mathematical models with limited empirical verification are an expensive way to establish public policy and seem a much lower standard of proof of efficacy than was required for other priority areas, e.g., HIV and sexual behavior.

17. Other Chronic Disorders

There was relatively little APHA comment in this area. Reviewers support targeted reductions in diabetes incidence and mortality. Eight of the 24 objectives appear in other priority areas; the highest priority objectives will be achieved if risk factors identified in other areas are satisfactorily addressed. It is not clear whether separate risk factor and health status objectives are needed to assure reaching the targets proposed for diabetes and osteoporosis.

The sensory impairments (e.g., legal blindness, 17.2; hearing impairment, 17.9; amblyopia/strabismus, 17.23; and noise awareness, 17.16) are a different matter. Except for one noise exposure objective (9.8, Occupational Safety and Health), they are not alluded to elsewhere.

18. Oral Health

Fluoridated water is a safe, effective means of preventing dental disease. APHA continues strong support of increasing coverage of the country with this measure (18.13), although the large increase proposed may be unrealistic. Systemic fluoride administration, a more expensive clinical approach, continues to be highly favored when water fluoridation is infeasible (18.14). We also strongly endorse the newer preventive technology of dental sealants (18.12), but we suggest target groups at increased risk of caries be identified.

As with other priority areas, there was a division as to whether the primary measurement should be of health outcomes (e.g., 18.4-18.7) or of intervention or risk factor prevalence. One reviewer pointed out that the two are highly intercorrelated, hence achievement of specific preventive goals will result in improvement of the health status.

There was considerable uncertainty about how the knowledge and awareness objectives 18.16, 18.17, and 18.18 would be measured. A lack of cross linkages with other priority areas was noted, particularly in the area of oral health care for HIV-infected persons. Care financing issues, identified as part of the previous priority area (Other Chronic Disorders) weren't addressed here, even though financial access is known to be a significant barrier to preventive dental care.

19. Mental and Behavioral Disorders

Most APHA reviewers concurred in the objective of reducing the prevalence of major mental disorders and ranked it at or near the top of priority lists (19.1). However, although the objectives reference "environmental events and conditions" in the genesis of some of these disorders, and even though "stress" is identified as a risk factor, no clue is presented as to the environmental conditions which might be addressed by a program -- a serious deficiency in these objectives.

Reducing the suicide rate (19.3; overlaps with 6.2) was highly ranked as an outcome measure, as was reducing morbidity due to stress (19.2). One reviewer noted that the proposed improvement in rates of health status measures might be less than the measurement error of the method used to determine population rates, an implicit criticism of the magnitude of improvement sought.

The risk factor (or perhaps more correctly co-morbidity) indicator goals related to educational performance (19.7-19.9) were viewed to be desirable by some, but unrealistic without additional resources. They could be combined into a single objective. As noted above, they are part of a constellation of risk behaviors which should be considered within a child health priority area.

Objectives in this area suffered from imprecision and lack of data. This may explain why there was relatively little correlation among APHA reviewers, particularly on lower-rated priorities. If a problem is not clearly stated and the measurement not well defined, it's not surprising that there is a wide range of variation in assessments of its importance. Community support services (19.14) and self-help clearinghouses (19.21) appeared to suffer from this deficiency, among many others.

The absence of public awareness objectives in this priority area was noted to be a particular weakness. For too long has the adage "Out of mind, out of sight." held sway in our society. Reviewers felt public attitudes needed to be confronted with accurate information.

Staff review of comments suggests that these objectives are considered to be among the weakest of the lot, which is unfortunate because of the tremendous health impact of these disorders.

20. Health Education and Preventive Services

There was again sharp disagreement within APHA about which objectives in the priority area were most important. This may have been exacerbated by the structure of the document, which placed these objectives together without any associated health status goals. One particularly cogent comment was, "The majority of these objectives are process and/or activities. The overall number of objectives should be reduced and those which are activities should be incorporated into an implementation document, rather than making the objectives document so large and cumbersome."

Reviewers noted overlaps in objectives,e.g., 20.1, 20.4 and 20.11 and emphasized severe data gaps. Those who favored preventive services liked the idea of the U.S. Preventive Services Task Force as an authority (although there are serious limitations on the overall applicability of that document due to its complete silence on major issues of reproductive health). School health education was strongly favored as the most important objective in this area by others.

The number of objectives lacking in baseline data, and the apparent overreliance on the medical model for prevention were two additional criticisms of the objectives in this priority area. APHA notes that the major victories of public health have historically been outside the arena of medical care and the medical model, though we recognize the value of specific clinical preventive services.

21. Surveillance and Data Systems

As noted under (20), these are exclusively process or activity steps, not health status objectives. There was much disagreement as to which steps were most important. One reviewer summed up possible reasons for the disagreement as follows: "Compared to all other priority areas, this area is poorly conceptualized and poorly presented."

The same reviewer noted the importance of this priority area and the demonstrated need for surveillance and data systems across all objectives. A formal analytical framework, in which each of the adopted objectives was evaluated with respect to its surveillance and data needs was suggested. Presented in tabular form, the analysis might contain comparisons of objectives on availability, quality, accessibility and usability of relevant surveillance data. A cross reference table might identify major data elements and systems, citing to which objective(s) they apply.

Identifying data elements, data sources and data systems had the favor of most reviewers. The issue of health indicators was also felt to be important by some. Carrying out the suggested analysis might be a way to approach the issue methodically.

Other comments related to how the objectives in this priority area might be implemented, requesting a phased development of the triennial evaluation (21.4) and a more collegial procedure for producing the health status indicators (21.7), which was tersely stated in the draft and sounded somewhat dictatorial as written.

APHA has long recognized the importance of accurate health data. We question whether this priority area is appropriate within the Year 2000 Objectives, however. Data system development is an implementation step for each objective and should be integral to each.

22. Global comments

A number of comments were received which were not pertinent to any particular objective area. Several individuals and groups noted the lack of attention to the social environment and its effect on health. One writer put is this way: "There needs to be more activity focusing on meeting other human and social service needs especially in the low income, under-served populations. Preventive and health education services will not be a priority for those whose basic need for food, clothing and shelter are not met."

Others expressed concern about the tendency to blame the victim inherent in so many process objectives which concentrated on individual behavior rather than environmental correction. These arguments would be less relevant if the draft dealt mostly with health status, but in spending so much time on process it opens the question of relative efficacy: should we educate people not to smoke or increase the price of cigarettes to make them less affordable to persons most susceptible to the tobacco addiction?

One reviewer wondered for whom the objectives were intended. If aimed at practitioners, the level of detail is appropriate; however if it is a public awareness document, it is much too complex. A shorter version, useable in the community, was proposed.

Finally, some advice on further development and involvement was offered. The "bottom up" planning process was advocated. The need for constituency building was emphasized. "Without a well developed implementation plan, reaching the Goals will be a process of the National leaders telling the local people how they should run their lives instead of a meaningful change on the systemic, community, and personal level."

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TESTIMONY FOR YEAR 2000 HEALTH OBJECTIVES

The Association of American Medical Colleges (AAMC) is a non-profit association representing all accredited U.S. Medical schools; the 16 accredited Canadian medical schools; 440 major teaching hospitals--including 77 Veterans Administration medical centers; 92 academic and professional societies, which represent 61,000 faculty members, and the national's medical students. It conducts a broad range of programs and studies on medical education, research and health care services and represents its members before Congress and the Executive Branch in pursuit of its mission--improving the nation's health through the advancement of academic medicine. The Division of Minority Health, Disease Prevention/Health Promotion assists member institutions to enlarge the pool of underrepresented minority applicants to medical school and to eliminate barriers to successful advancement at all levels of academic medicine. Furthermore, it develops strategies and programs to improve the health status of minority populations, with a particular emphasis on prevention of disease and disability. Additionally, the AAMC is a member of the Year 2000 Health Objectives Consortium Organizations.

The United States of America, despite having one of the highest standards of living and the highest per capita spending in the world on medical care, lags behind other nations, including some "third world" countries in many health indicators, particularly when the health status of some U.S. minority groups is viewed apart. For instance, while life expectancy overall has increased since 1900, that of blacks is still lower than for whites and has actually decreased over the past 3 years for which we have data. In terms of infant mortality, the U.S. overall ranks 19th. Infant mortality in some regions such as Mississippi and Washington, D.C., is actually worse than some developing nations.

The Year 2000 Health Objectives for the Nation represent a unique challenge for the U.S. health care system, including academic medical centers, for the next decade. The central theme of this challenge is to implement prevention strategies in all aspects of the health care delivery system. Today, a sizeable proportion of deaths occurring in the United States are the result of risk factors which if prevented or ameliorated could results in lower death rates. According to "Closing the Gap: The Burden of Unnecessary Illness" nearly 95 percent of deaths in 1980 could be attributed to issues of lifestyle, poor health behaviors (such as smoking, excessive of alcohol use and illicit drugs) and gaps in primary prevention. Three risk factors--tobacco, high blood pressure and overnutrition--accounted for nearly three-quarters of premature deaths in the United States in 1980.(1987) For adolescents, three causes of death, all considered preventable, account for nearly three-fourths of all deaths: injuries, homicides and suicides.

The objectives outlined for the Year 2000 encompass a broad range of health concerns which impact on virtually every segment of our society. Of particular importance are those objectives which target special populations such as minority groups, low income individuals, and various age groups (adolescents, children, and the elderly). These objectives acknowledge the disparity in health status and risk that historically has existed, and continues to exist, among various segments in our population. They should not, however, be construed as acceptance of that disparity. If these objectives are met by the Year 2000, the gap in health status and risk between various groups will be greatly lessened with the likelihood that the gap could potentially be eliminated.

Achievement of these goals, though, is dependent upon the commitment of resources, both professional and financial, at various levels of our society.

To this end, the National Health Objectives Act for the Year 2000 begins to provide the federal financial assistance needed for states and communities to implement this ambitious program.

However, it is increasingly imperative that new sectors of society be involved in these endeavors. "Health" must no longer be a concern for only health professionals. Educators, social service agencies, private industry and communities as a whole must commit themselves to promoting wellness.

As part of the effort to achieve the Year 2000 Health Objectives, academic medical centers play a critical role in the training of competent professionals to meet today's health challenges. In turn, the Year 2000 Objectives can serve to focus attention of academic medical centers on specific curricula and training, at undergraduate, graduate and continuing education levels, to meet the health needs of the U.S. The professional training objectives in areas such as violent and abusive behavior, mental and behavioral disorders, HIV infection, cancer, and injury reduction point to the need for increasing medical education in preventive health issues. These objectives, as well as others, provide further encouragement to medical schools to implement the recommendation from the report of AAMC's Panel on the General Professional Education of the Physician (GPEP) that "Medical students' general professional education should include an emphasis on the physician's responsibility to work with individual patients and communities to promote health and prevent disease." (1984) While medical education by necessity must focus on repair and cure of the effects of disease and injury, it must also provide education in promoting health and preventing disease or injury.

It is heartening for us to see an increased emphasis on health services research. Specific research on preventive strategies will be important for our institutions to take part in, and the results of that research will provide important guidance for which preventive interventions are efficacious and cost effective.

The physicians of today and those of the 21st century, particularly those in primary care, will encounter morbidity and mortality which increasingly will have their etiology rooted in behavior and lifestyle circumstances. These health problems can only be optimally addressed by combining prevention with cure. Physicians will be called upon to provide care in which counselling about lifestyle and behaviors, as well as screening for disease, will be an indispensable part of that physician's armamentarium.

The AAMC appreciates this opportunity to work with the Senate Governmental Affairs Subcommittee on Governmental Information and Regulation to promote the Year 2000 Health Objectives for the Nation. We also would welcome the opportunity to work with the Subcommittee on future efforts involving these health objectives.

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SCHOOL OF NURSING
DEPARTMENT OF SOCIAL AND BEHAVIORAL SCIENCES
N-631-Y
SAN FRANCISCO, CALIFORNIA 94143-0612

March 12, 1990

Senator Jeff Bingaman
Chair, Senate Subcommittee on Government
Information and Regulation
502 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Bingaman:

I am writing to express my urgent concern regarding the totally inadequate proposed FY 1991 President's budget for the National Center for Health Statistics (NCHS), the federal agency that has responsibility for the collection, analysis, and dissemination of statistics on the health of the nation.

Let me introduce myself. I was Director of NCHS from January 1976 to June 1982. I am a medical economist and statistician by profession and am currently Professor in the Department of Social and Behavioral Sciences, School of Nursing at the University of California at San Francisco. I am a member of the Institute of Medicine, and a fellow of the American Statistical Association and of the American Public Health Association. I currently serve on the Committee on National Statistics of the National Academy of Sciences and the National Advisory Council on Aging.

In my current multiple roles and, especially, as a former Director of NCHS, I have closely monitored the activities and budget of NCHS. I am currently conducting research on cost of illness, aging, chronic illness, and disability. In all of my research, I use national health data produced by NCHS.

The proposed FY 1991 budget for NCHS is inadequate to collect data that are vital to monitoring the health of the nation. For FY 1991, the President's budget request includes $48.1 million for NCHS, a decrease of $0.4 million from the FY 1990 level, and an approximate 5 percent reduction in real dollars. The FY 1991 budget also proposes that $19.0 million in Public Health Service "evaluation funds" be made available to provide funding for NCHS activities, representing no increase from FY 1990. The decrease in funding proposed for NCHS programs in FY 1991, coupled with significant cost increases associated with continuing the Center's ongoing survey operations, will leave the agency with a significant shortfall in the funds required to operate its data systems at planned levels.

It is my understanding that no final decisions have been made to curtail the NCHS programs, but it appears that there are only two strategies that would accommodate the proposed level of resources: The National Health Interview Survey, one of the country's major surveys, could be eliminated in 1991. Alternatively, NCHS could implement across-the-board reductions in all major data systems. **Both of these options are unacceptable.** Let me explain:

Option 1: Eliminate the National Health Interview Survey (NHIS) for One Year

The NHIS was one of the earliest national surveys initiated by the Public Health Service and was included as part of NCHS when it was formed in 1960. NHIS was inaugurated in July 1957 and has been in operation continuously to the present time. The survey is designed to obtain information essential to researchers, policy planners, and decision makers who are attempting to steer the fastest growing major industry in the United States -- the health care system -- currently consuming more than 11 percent of our GNP. NHIS data are used for: 1) administrative planning and evaluation of government and voluntary programs in the field of health; 2) evaluating the demand for medical, dental, and other health care services in relation to the supply of facilities and personnel to meet the health needs of the nation; 3) developing hypotheses for the conduct of medical research; 4) providing essential data for business in estimating markets for drugs and appliances; 5) public health education programs; and 6) monitoring the health objectives of the nation.

The survey provides a continuing flow of information on the volume and character of illness and disability, the medical care received, and related demographic, social, and economic variables. The emphasis in NHIS is on the social dimensions of morbidity and the effect that morbidity has on the lives of the American people.

The survey covers the civilian noninstitutionalized population of the United States living at the time of the interview. Interviews are conducted each week throughout the year in a probability sample of households. The interviewing is conducted by a permanent staff of carefully trained and supervised interviewers of the Bureau of the Census under detailed specifications of the National Center for Health Statistics. Data collected over the period of a year are published annually as estimates of the health characteristics studied, which form the basis for studying trends in those characteristics.

The quality of NHIS data would be seriously compromised if it were eliminated for one year because the permanent staff of experienced interviewers and supervisors would be lost forever. These interviewers would have no trouble finding new jobs and they would not return to interviewing for the NHIS. Undoubtedly, the more productive personnel would be attracted to permanent programs that could offer an opportunity of continuous employment. The central office administrative field personnel would be assigned to the survey based primarily on their availability and not necessarily on their knowledge of the NHIS program. Those staff with higher levels of seniority who have long-term experience and knowledge of NHIS would most likely be transferred to programs providing continuous employment. The importance of having an experienced, knowledgeable, and stable field staff cannot be over-emphasized. Significant reductions in interviewer-specific nonresponse rates (up to 50 percent) occur in the first 12 months after a new interviewer is hired. Likewise, interviewer item error rates fall rapidly in the first year on the job and reach a minimum only after 2 1/2 to 3 years. We cannot afford to jeopardize the quality of the NHIS data in this way.

Additionally, one of the major advantages of the current continuous NHIS design is that the data can be pooled over a number of quarters or years to increase the precision of the estimate under the assumption that the underlying system affecting the estimate does not change over the time being pooled. This allows combining 2 or 3 years of data for many rare events. In the past, 3 consecutive years of NHIS data have been used to develop composite estimates.

My personal experience at NCHS also indicates that once a survey is discontinued, it is difficult, if not impossible, to reinstate it on a continuing basis. For example, the National Ambulatory Care Survey was an annual survey from 1974 to 1981. Budget constraints forced me as NCHS Director to postpone the survey in 1982. The survey was finally conducted again in 1985. If NHIS is eliminated for one year, its fate as a continuing survey will be in great jeopardy.

Elimination of NHIS for one or more years will mean that the nation will lose its capacity to monitor progress toward the National Health Objectives for the Year 2000. Most of the 1990 Objectives for the Nation relied on the NHIS and the Year 2000 Objectives were developed on the basic assumption that the NHIS will continue to produce annual data that would be used to monitor the health of the nation.

An important use of NHIS in the past has been to make national estimates of the prevalence and severity of new and critical issues, such as AIDS, as they emerge. Adding a few questions to the existing survey for a short period of time has proved to be a very cost-effective method of collecting timely health data. An example is the AIDS Knowledge and Awareness Survey that produced monthly data in 1988. The nation cannot afford to lose this capability for responding to burning questions by eliminating NHIS.

Option 2: Across-the-Board Reductions

This option is to implement across-the-board reductions in all major NCHS activities, requiring cuts in each program, including: reductions in the Vital Health Statistics system (the marriage and divorce components, as well as other data items); a reduced sample size in the NHIS; suspension of plans to conduct components of the National Health Care Survey, now being reviewed by the Institute of Medicine; and the furlough of one or two field teams in the National Health and Nutrition Examination Survey (NHANES III), causing a slowdown in data collection and availability of data to monitor the nation's nutritional status.

Cutting all the NCHS data systems under this option also is unacceptable. Reducing sample sizes of continuing national sample surveys such as the NHIS and the National Hospital Discharge Survey (NHDS) means that the kind of data for which there are the greatest needs would not be available. For example, disaggregation of survey results for social and ethnic minorities would be seriously compromised. At a time when we need more, not less, accurate statistics on the health of minority and ethnic groups, we would not be able to produce them. Again, accurately monitoring the health of the nation and our progress toward the Year 2000 objectives would be impossible.

In summary, the options available to NCHS under the President's FY 1991 budget are too destructive and therefore not acceptable. The core budget of NCHS has remained at about $48 million since FY 1988. There have been no increases to allow for inflation. NCHS, or any other agency, cannot continue to conduct its essential data collection, analysis, and dissemination activities with a level budget. Chipping away at these activities from year to year is not the answer.

NCHS is the only major agency within the Federal statistics system whose budget was reduced for FY 1991. Increases ranged from 4 percent for the Energy Information Administration to 52 percent for the National Center for Education Statistics. The growing health care industry coupled with escalating health care costs require timely, accurate, and detailed statistics to monitor the health of the nation. It is incomprehensible and unconscionable that the NCHS core budget is reduced. The NCHS budget for FY 1991 must be increased substantially, by at least $10 million, to enable it to carry out its essential activities.

I hope you will give this matter your immediate and urgent attention and consideration.

Sincerely,

Dorothy P. Rice

Dorothy P. Rice
Professor

DPR/kj

Health United States 1989

and Prevention Profile

U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
National Center for Health Statistics

Selected Highlights

- Between 1986 and 1987 overall life expectancy at birth increased from 74.8 to 75.0 years; life expectancy for black males remained unchanged.
- The percent of live-born infants weighing less than 2,500 grams has been essentially unchanged since 1980 at 7%. However, there are large differences among ethnic and racial groups. Black infants had the highest rate (12.7% in 1987), followed by Puerto Ricans (9.3%), Asians (6.4%), and American Indians (6.2%). Cuban, Mexican, and non-Hispanic white infants have rates between 5.6 and 5.9%.
- In 1987 the infant mortality rate was 10.1 deaths per 1,000 live births, 12% above the 1990 national goal of 9.0. Among black infants the infant mortality rate declined by less than 1% between 1986 and 1987 to 17.9; the fetal death rate increased by 2.4%.
- The age-adjusted death rate for heart disease, the leading cause of death, declined by 33% from 1970 to 1987; the age-adjusted death rate for stroke declined by 54% over this period.
- Between 1984 and 1987 the death rate for homicide increased by 39% for black males 15–24 years old to about the same level as in 1980. In 1987 the homicide rate for black males in this age group (85.6 per 100,000) was 7 times the rate for white and 43% above the 1990 objective of 60.0.
- The death rate for adults 25–64 years of age dropped from 533 per 100,000 population in 1977 to 423 in 1987. The 1987 rate was just 6% above the 1990 national goal of 400.
- Between 1984 and 1988 the sex and race distribution of persons 13 years and over reported as AIDS cases shifted somewhat. The percent female increased from 6 to 10, and the percent black increased from 25 to 29; the percent Hispanic remained at 14.
- Homosexual and bisexual activity as an HIV transmission category accounted for over 77% of the 36,000 deaths among white non-Hispanic AIDS cases 13 years of age and over compared to 38% of the 17,600 black non-Hispanic AIDS deaths and 53% of the Hispanic AIDS deaths. By contrast, 7% of the white non-Hispanic deaths, 37% of the black non-Hispanic deaths, and 24% of the Hispanic deaths were transmitted by intravenous drug use.
- In 1987, 29% of adults 18 years and over smoked cigarettes, just above the 1990 objective of 25%. However, between 1974 and 1987 age-adjusted prevalence of current smoking among persons 25 years and over declined by only 7% for those with less than a high school education compared with a 39% decline for college graduates.
- In 1987 national health care expenditures in the United States totaled $500 billion, an average of $1,987 per person.
- In 1988 the rate of increase in the medical care component of the Consumer Price Index was 6.5% compared with an overall inflation rate of 4.1%.
- Expenditures for HIV-related activities by the Federal Government increased from $6 million in 1982 to $1.5 billion in 1988.

Fertility and natality [tables 2, 3, 6, 7]	*1970*	*1980*	*1985*	*1986*	*1987*
	Live births in thousands				
Live births	3,731	3,612	3,761	3,757	3,809
	Live births per 1,000 women 15–44 years of age				
Fertility rate	87.9	68.4	66.2	65.4	65.7
White	84.1	64.7	63.0	61.9	62.0
Black	115.4	88.1	82.2	82.4	83.8
Natality characteristics	Percent of live births				
Birth weight less than 2,500 grams	7.9	6.8	6.8	6.8	6.9
White	6.8	5.7	5.6	5.6	5.7
Black	13.9	12.5	12.4	12.5	12.7
Asian and Pacific Islander	8.4	6.6	6.1	6.4	6.4
American Indian	8.0	6.5	5.9	6.2	6.2
Hispanic:					
Mexican	---	5.6	5.8	5.6	5.7
Puerto Rican	---	8.9	8.7	9.2	9.3
Cuban	---	5.6	6.0	5.5	5.9
Unmarried mothers	10.7	18.4	22.0	23.4	24.5
White	5.7	11.0	14.5	15.7	16.7
Black	37.4	55.2	60.1	61.2	62.2
Asian and Pacific Islander	7.8	7.8	10.1	10.6	11.5
American Indian	19.8	33.5	40.7	42.3	44.9
Hispanic:					
Mexican	---	20.5	25.7	27.9	28.9
Puerto Rican	---	46.3	51.1	52.6	53.0
Cuban	---	10.0	16.1	15.8	16.1
Prenatal care began during 1st trimester	68.0	76.3	76.2	75.9	76.0
White	72.4	79.3	79.4	79.2	79.4
Black	44.4	62.7	61.8	61.6	61.1
Asian and Pacific Islander	67.8	74.7	75.0	75.6	75.7
American Indian	41.7	58.7	60.3	60.7	60.2
Hispanic:					
Mexican	---	59.6	60.0	58.9	60.0
Puerto Rican	---	55.1	58.3	57.2	57.4
Cuban	---	82.7	82.5	81.8	83.1

SOURCE: National Center for Health Statistics, National Vital Statistics System.

--- Data not available.

Mortality [tables 14, 15, 22, 24]	*1970*	*1980*	*1985*	*1986*	*1987*
Life expectancy in years					
Life expectancy at birth	70.9	73.7	74.7	74.8	75.0
Male	67.1	70.0	71.2	71.3	71.5
White	68.0	70.7	71.9	72.0	72.2
Black	60.0	63.8	65.3	65.2	65.2
Female	74.8	77.4	78.2	78.3	78.4
White	75.6	78.1	78.7	78.8	78.9
Black	68.3	72.5	73.5	73.5	73.6
Deaths per 1,000 live births					
Infant mortality rate[1]	20.0	12.6	10.6	10.4	10.1
White	17.8	11.0	9.3	8.9	8.6
Black	32.6	21.4	18.2	18.0	17.9
Neonatal mortality rate[2]	15.1	8.5	7.0	6.7	6.5
White	13.8	7.5	6.1	5.8	5.5
Black	22.8	14.1	12.1	11.7	11.7
Postneonatal mortality rate[3]	4.9	4.1	3.7	3.6	3.6
White	4.0	3.5	3.2	3.1	3.1
Black	9.9	7.3	6.1	6.3	6.1
Deaths per 1,000 live births plus fetal deaths					
Fetal death rate[4]	14.0	9.1	7.8	7.7	7.6
White	12.3	8.1	7.0	6.7	6.6
Black	23.2	14.4	12.6	12.5	12.8
Deaths in thousands					
Deaths	1,921	1,990	2,086	2,105	2,123
Deaths per 100,000 resident population					
Death rate, crude	945.3	878.3	873.9	873.2	872.4
Death rate, age adjusted	714.3	585.8	546.1	541.7	535.5
Under 1 year	2,142.4	1,288.3	1,067.8	1,032.1	1,018.5
1–4 years	84.5	63.9	51.4	52.0	51.6
5–14 years	41.3	30.6	26.3	26.0	25.6
15–24 years	127.7	115.4	95.9	102.3	99.4
25–34 years	157.4	135.5	123.4	132.1	133.2
35–44 years	314.5	227.9	207.2	212.9	214.1
45–54 years	730.0	584.0	516.3	504.8	498.0
55–64 years	1,658.8	1,346.3	1,282.7	1,255.1	1,241.3
65–74 years	3,582.7	2,994.9	2,838.6	2,801.4	2,751.3
75–84 years	8,004.4	6,692.6	6,445.1	6,348.2	6,282.5
85 years and over	16,344.9	15,980.3	15,480.3	15,398.9	15,320.8

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[1] Deaths of infants under 1 year.

[2] Deaths within 28 days of birth.

[3] Deaths occurring 28-365 days after birth.

[4] Deaths of fetuses of 20 weeks or more gestation.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

Mortality [tables 22, 23]	*1970*	*1980*	*1985*	*1986*	*1987*
Death rate, age adjusted	Deaths per 100,000 resident population				
White male	893.4	745.3	688.7	679.8	668.2
Black male	1,318.6	1,112.8	1,024.0	1,026.9	1,023.2
White female	501.7	411.1	390.6	387.7	384.1
Black female	814.4	631.1	589.1	586.2	586.2
Diseases of heart	253.6	202.0	180.5	175.0	169.6
White male	347.6	277.5	244.5	234.8	223.9
Black male	375.9	327.3	301.0	294.3	287.1
White female	167.8	134.6	121.7	119.0	116.3
Black female	251.7	201.1	186.8	185.1	190.8
Cerebrovascular diseases	66.3	40.8	32.3	31.0	30.3
White male	68.8	41.9	32.8	31.1	30.3
Black male	122.5	77.5	60.8	58.9	57.1
White female	56.2	35.2	27.9	27.1	26.3
Black female	107.9	61.7	50.3	47.6	46.7
Malignant neoplasms	129.8	132.8	133.6	133.2	132.9
White male	154.3	160.5	159.2	158.8	158.4
Black male	198.0	229.9	231.6	229.0	227.9
White female	107.6	107.7	110.3	110.1	109.7
Black female	123.5	129.7	130.4	132.1	132.0
Respiratory cancer	28.4	36.4	38.8	39.0	39.7
White male	49.9	58.0	58.2	58.0	58.6
Black male	60.8	82.0	84.4	83.9	84.2
White female	10.1	18.2	22.6	23.1	23.8
Black female	10.9	19.5	22.5	23.3	24.3
Breast cancer[1]	23.1	22.7	23.2	23.1	22.9
White	23.4	22.8	23.3	23.0	22.8
Black	21.5	23.3	25.3	25.8	26.5
Chronic obstructive pulmonary diseases	13.2	15.9	18.7	18.8	18.7
White male	24.0	26.7	28.5	28.1	27.4
Black male	---	20.9	23.9	24.6	24.0
White female	5.3	9.2	12.9	13.3	13.7
Black female	---	6.3	8.7	8.9	9.5

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[1] Female only.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

Mortality [table 23]	*1970*	*1980*	*1985*	*1986*	*1987*
Death rate, age adjusted—Con.	Deaths per 100,000 resident population				
Pneumonia and influenza	22.1	12.9	13.4	13.5	13.1
White male	26.0	16.2	17.4	17.5	16.8
Black male	53.8	28.0	26.8	27.2	26.4
White female	15.0	9.4	9.8	9.9	9.7
Black female	29.2	12.7	12.4	13.1	12.2
Chronic liver disease and cirrhosis	14.7	12.2	9.6	9.2	9.1
White male	18.8	15.7	12.6	12.2	12.1
Black male	33.1	30.6	23.4	20.8	22.0
White female	8.7	7.0	5.6	5.4	5.1
Black female	17.8	14.4	10.1	9.3	9.1
Human immunodeficiency virus	---	---	---	---	5.5
White male	---	---	---	---	8.3
Black male	---	---	---	---	25.4
White female	---	---	---	---	0.6
Black female	---	---	---	---	4.7
Accidents and adverse effects	53.7	42.3	34.7	35.2	34.6
White male	76.2	62.3	50.4	51.1	49.7
Black male	119.5	82.0	66.7	66.9	66.8
White female	27.2	21.4	18.4	18.4	18.6
Black female	35.3	25.1	20.7	21.0	21.0
Motor vehicle accidents	27.4	22.9	18.8	19.4	19.5
White male	40.1	34.8	27.6	28.7	28.4
Black male	50.1	32.9	27.7	29.2	28.5
White female	14.4	12.3	10.8	11.0	11.4
Black female	13.8	8.4	8.2	8.5	8.7
Suicide	11.8	11.4	11.5	11.9	11.7
White male	18.2	18.9	19.9	20.5	20.1
Black male	9.9	11.1	11.3	11.5	12.0
White female	7.2	5.7	5.3	5.4	5.3
Black female	2.9	2.4	2.1	2.4	2.1
Homicide and legal intervention	9.1	10.8	8.3	9.0	8.6
White male	7.3	10.9	8.1	8.4	7.7
Black male	82.1	71.9	49.9	55.9	53.8
White female	2.2	3.2	2.9	2.9	2.9
Black female	15.0	13.7	10.8	11.6	12.3

SOURCE: National Center for Health Statistics, National Vital Statistics System.

Acquired immunodeficiency syndrome (AIDS) [tables 42, 44]	*All years*[1,2]	*1984*	*1986*	*1988*	*1989*[2]
	Number of cases				
Cases, all ages	106,270	4,445	13,167	30,947	25,467
Under 13 years	1,773	50	186	570	472
13 years and over	104,497	4,395	12,981	30,377	24,995
Male	95,231	4,118	12,011	27,313	22,442
White, not Hispanic	58,462	2,611	7,545	16,256	13,305
Black, not Hispanic	23,648	947	2,765	7,151	6,046
Hispanic	12,192	538	1,592	3,645	2,815
Female	9,266	277	970	3,064	2,553
White, not Hispanic	2,668	79	272	864	723
Black, not Hispanic	5,045	141	523	1,663	1,438
Hispanic	1,449	57	162	502	357
Male homosexual or bisexual	64,726	2,867	8,521	17,911	14,670
Intravenous (IV) drug use	20,590	776	2,231	6,819	5,341
Male homosexual or bisexual and IV drug use	7,250	408	988	1,946	1,519
Hemophilia or coagulation disorder	1,002	36	123	298	219
Born in Caribbean or African countries	1,530	110	220	375	235
Heterosexual	3,310	57	334	1,122	1,025
Sexual contact with IV drug user	2,367	42	231	817	734
Transfusion	2,571	52	305	836	550
Undetermined	3,518	89	259	1,070	1,367

Current cigarette smokers [table 53]	*1965*	*1979*	*1983*	*1987*
18 years of age and over, age adjusted	Percent			
Male	51.6	37.2	34.7	31.0
White	50.8	36.5	34.1	30.4
Black	59.2	44.1	41.3	39.0
Female	34.0	30.3	29.9	26.7
White	34.3	30.6	30.1	27.2
Black	32.1	30.8	31.8	27.2

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[1] Includes cases reported in 1981–September 30, 1989.
[2] Data are as of September 30, 1989, and reflect reporting delays.

NOTES: The AIDS case definition was changed in September 1987. Data exclude residents of U.S. territories.

SOURCES: Centers for Disease Control, Center for Infectious Diseases, AIDS Program; National Center for Health Statistics, National Health Interview Survey.

Ambulatory care [tables 64,65]	*1964*	*1983*	*1988*
		Percent	
Last physician contact 2 or more years ago, age adjusted	19.1	13.9	12.4
Under 15 years	16.7	8.5	7.1
15–44 years	18.7	16.6	15.5
45–64 years	22.5	17.0	14.9
65 years and over	21.0	11.9	9.4
		Number per person	
Physician contacts, age adjusted	---	5.1	5.3
Under 15 years	---	4.6	4.6
15–44 years	---	4.4	4.7
45–64 years	---	5.8	6.1
65 years and over	---	7.6	8.7

Inpatient care [table 70]	*1980*	*1985*	*1986*	*1987*	*1988*[1]
Non-Federal short-stay hospitals			Number per 1,000 population		
Hospital discharges, age adjusted	159.1	138.0	132.8	127.9	117.8
Under 15 years	71.6	57.2	53.5	51.3	49.2
15–44 years	150.2	125.1	118.9	115.1	104.0
45–64 years	194.8	169.5	162.2	156.9	140.5
65 years and over	383.7	368.3	367.3	350.5	334.1
Days of care, age adjusted	1,136.5	877.1	833.1	808.7	754.8
Under 15 years	315.8	260.8	244.7	240.6	245.3
15–44 years	787.0	603.6	575.7	556.9	493.1
45–64 years	1,597.6	1,192.8	1,101.4	1,068.6	955.3
65 years and over	4,098.3	3,215.1	3,120.7	3,029.9	2,970.0
			Days		
Average length of stay, age adjusted	7.1	6.4	6.3	6.3	6.4
Under 15 years	4.4	4.6	4.6	4.7	5.0
15–44 years	5.2	4.8	4.8	4.8	4.7
45–64 years	8.2	7.0	6.8	6.8	6.8
65 years and over	10.7	8.7	8.5	8.6	8.9

Nursing home residents [table 77]	*1973–74*	*1977*	*1985*
		Residents per 1,000 population	
65 years and over	44.7	47.1	46.2
65–74 years	12.3	14.4	12.5
75–84 years	57.7	64.0	57.7
85 years and over	257.3	225.9	220.3

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[1] Comparisons of 1988 data with data for earlier years should be made with caution as estimates of change between 1987 and 1988 may reflect improvements in the 1988 design rather than true changes in hospital use.

SOURCES: National Center for Health Statistics, National Health Interview Survey, National Hospital Discharge Survey, National Nursing Home Survey.

Mental health care [table 79]	*1969*	*1975*	*1983*	*1986*
	Admissions in thousands			
Inpatient and residential	1,283	1,558	1,633	1,817
Outpatient	1,147	2,291	2,663	2,765
Partial care	55	163	177	189
	Admissions per 100,000 civilian population			
Inpatient and residential	644.2	736.5	701.4	759.9
Outpatient	575.9	1,083.2	1,147.5	1,155.7
Partial care	27.8	77.2	76.3	78.9

Health care resources [tables 87, 93, 99]	*1970*	*1980*	*1987*
	Number in thousands		
Physicians, active non-Federal M.D.'s	279	393	494
Dentists	96	121	140
Registered nurses	750	1,273	1,627
	Number per 100,000 civilian population		
Physicians, active non-Federal M.D.'s	137.0	174.9	204.3
Dentists	47.0	53.5	57.8
Registered nurses	368.9	560.0	668.5
	Number		
Short-stay hospitals	6,193	6,229	5,967
Beds in thousands	936	1,080	1,046
	1976	*1982*	*1986*
Nursing homes, 25 or more beds	14,133	14,565	16,033
Beds in thousands	1,292	1,469	1,616

SOURCES: National Institute of Mental Health. American Medical Association. Health Resources and Services Administration. American Hospital Association (Copyright; used with permission of American Hospital Association). National Center for Health Statistics, National Master Facility Inventory.

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National health expenditures [tables 100, 102]	*1965*	*1980*	*1985*	*1986*	*1987*
Amount in billions	$41.9	$248.1	$419.0	$455.7	$500.3
Percent of gross national product	5.9	9.1	10.4	10.7	11.1
Amount per capita	$206	$1,055	$1,696	$1,827	$1,987
			Percent of total		
Hospital care	33	41	40	39	39
Physician services	20	19	19	20	21
Dentist services	7	6	6	6	7
Nursing home care	5	8	8	8	8

Consumer Price Index [table 107]	*1980–85*	*1985–86*	*1986–87*	*1987–88*
	Average annual percent change			
All items	5.5	1.9	3.6	4.1
All medical care	8.7	7.5	6.6	6.5
Physician services	8.2	7.2	7.3	7.2
Dental services	7.7	5.6	6.8	6.8
Hospital rooms	11.2	6.0	7.2	9.3
Prescription drugs	10.6	8.6	8.0	8.0

Hospital expenses and personnel [table 108]	*1971*	*1980*	*1985*	*1986*	*1987*
Expenses for inpatient care					
Amount in billions	$22.4	$ 77.0	$130.7	$140.9	$152.9
Expenses per inpatient day	83	244	460	499	537
Expenses per inpatient stay	667	1,844	3,239	3,530	3,849
Hospital personnel			Number		
Personnel in thousands	1,999	2,879	3,003	3,032	3,120
Personnel per 100 patients	272	334	385	392	400

SOURCES: Health Care Financing Administration. Bureau of Labor Statistics. American Hospital Association (Copyright; used with permission of American Hospital Association).

For additional information, contact:
Scientific and Technical Information Branch
National Center for Health Statistics
3700 East-West Highway, Room 1-57
Hyattsville, Maryland 20782
Phone: (301) 436-8500

Personal health care expenditures [tables 110, 129]	*1965*	*1980*	*1985*	*1986*	*1987*
Amount in billions	$35.9	$219.7	$368.3	$401.6	$442.6
Amount per capita	176	934	1,490	1,610	1,758
Source of funds			Percent of total		
Government funds	22.0	39.4	40.2	39.7	39.6
Federal funds	10.1	28.4	30.2	30.0	29.6
State and local funds	11.9	10.9	10.0	9.8	10.0
Private health insurance	24.2	30.7	30.4	31.0	31.4
Direct payment	51.6	28.7	28.2	28.0	27.8

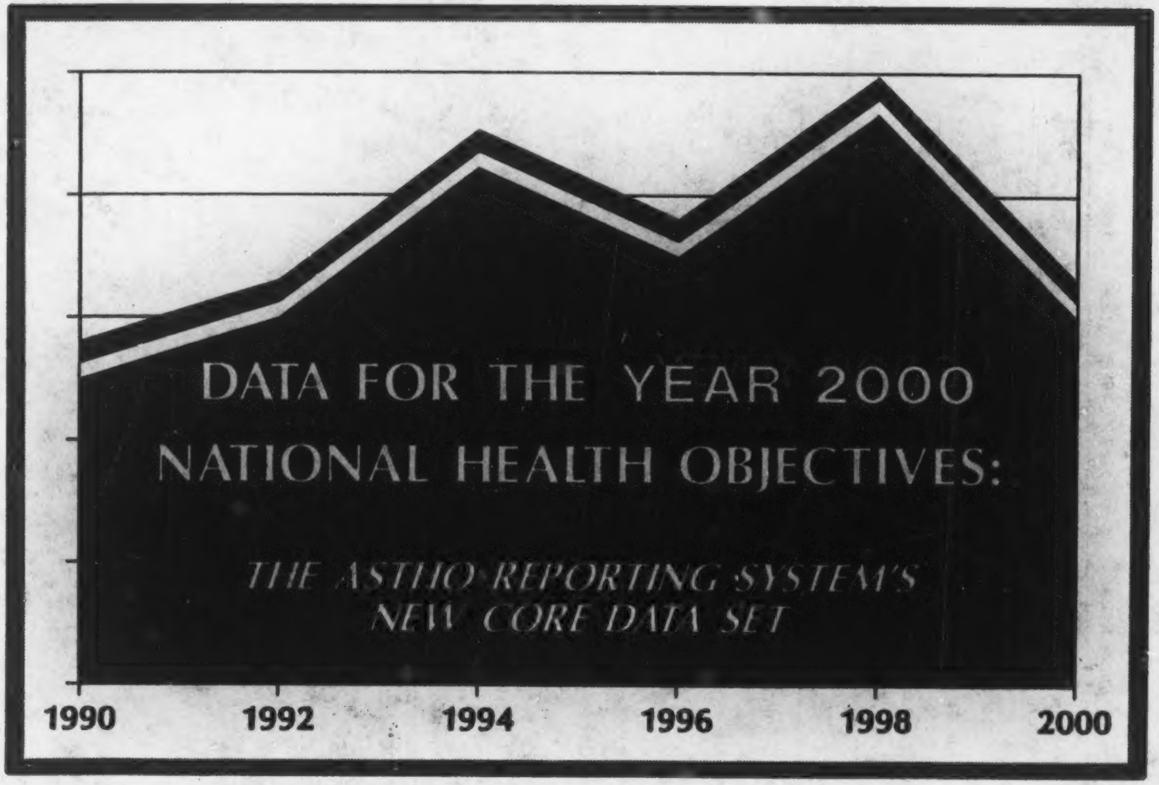
Health care coverage [tables 121, 122]	*1980*	*1982*	*1986*
Under 65 years of age, age adjusted		Percent	
Private insurance	78.8	77.3	75.9
Medicaid	5.9	5.6	5.9
Not covered	12.5	14.7	15.3
Under 15 years of age			
Private insurance	74.7	72.7	71.4
Medicaid	10.2	9.8	10.4
Not covered	12.8	15.8	16.1
65 years of age and over, age adjusted			
Medicare and private insurance	64.4	65.5	71.6
Medicare and Medicaid	8.1	6.1	5.8
Medicare	22.7	23.1	17.9

SOURCES: Health Care Financing Administration, National Center for Health Statistics, National Health Interview Survey.

Medicare [table 124]	*1967*	*1980*	*1986*	*1987*	*1988*
Enrollment in millions	19.5	28.5	31.7	32.4	33.0
Hospital insurance	19.5	28.1	31.2	31.8	---
Supplementary medical insurance	17.9	27.4	30.6	31.2	---
Expenditures in billions	$4.7	$36.8	$77.7	$82.0	$88.6
Hospital insurance	3.4	25.6	50.4	50.3	53.3
Supplementary medical insurance	1.3	11.2	27.3	31.7	35.2

Medicaid [table 127]	*1972*	*1980*	*1986*	*1987*	*1988*
Recipients in millions	17.6	21.6	22.5	23.1	22.9
	Percent of total				
Aged, 65 years and over	18.8	15.9	13.9	14.1	13.8
Blind and disabled	9.8	13.5	14.2	14.6	15.2
Adults in AFDC families	17.8	22.6	25.1	24.2	24.0
Children in AFDC families	44.5	43.2	44.4	44.0	43.8
Vendor payments in billions	$6.3	$23.3	$41.0	$45.0	$48.7
	Percent of total				
Aged, 65 years and over	30.6	37.5	36.8	35.6	35.2
Blind and disabled	22.2	32.7	36.4	37.3	38.2
Adults in AFDC families	15.3	13.9	11.9	12.4	12.1
Children in AFDC families	18.1	13.4	12.5	12.2	12.0

SOURCE: Health Care Financing Administration.



DATA FOR THE YEAR 2000 NATIONAL HEALTH OBJECTIVES:

THE ASTHO REPORTING SYSTEM'S NEW CORE DATA SET

PHF Public Health Foundation
Established by the Association of State and Territorial Health Officials

DATA FOR THE YEAR 2000 NATIONAL HEALTH OBJECTIVES:
THE ASTHO REPORTING SYSTEM'S NEW CORE DATA SET

APRIL 1990

Public Health Foundation
1220 L Street, N.W.
Washington, D.C. 20005

FOREWORD

This document, *Data for the Year 2000 National Health Objectives: the ASTHO Reporting System's New Core Data Set*, is a sampler of graphics displaying information that will be available in the near future through the Public Health Foundation's ASTHO Reporting System. The Foundation, with support and assistance from the Maternal and Child Health Bureau/Health Resources and Services Administration and the Center for Chronic Disease Prevention and Health Promotion/Centers for Disease Control, has designed a new core data set for the ASTHO Reporting System that is outcome-oriented and focuses on public health priorities. The new data set will initially address nine broad public health goals identified in the Year 2000 Objectives.

The new core data set represents a major step toward implementing recommendations made by the Institute of Medicine in the report, *The Future of Public Health*, and by the U.S. Department of Health and Human Services in the Year 2000 Objectives for the Nation. The Institute of Medicine report called for the establishment of a uniform national data set that would permit valid comparisons among states and that would help states monitor their progress toward attaining the national health objectives. The Year 2000 Objectives identified, as a national priority, the development of a set of common data elements related to the objectives. The Foundation's new core data set will provide the necessary data to tell a compelling story about the impact public health agencies are having on desired health outcomes and on the national effort to meet the Year 2000 Objectives.

We are indebted to the 51 individuals from federal, state, and local health agencies who devoted three days of time and creative energy to the Foundation's National Core Data Workshop in Scottsdale, Arizona. Their enthusiasm and commitment resulted in the design of hundreds of graphics that define the new core data set. We would especially like to thank the chairpersons of the four work groups, Claude Earl Fox, M.D., State Health Officer, Alabama Department of Public Health (maternal and child health work group); John T. Tierney, Deputy Director of Health, Rhode Island Department of Health (chronic disease work group); Mary L. Ellis, Director of Public Health, Iowa Department of Public Health (co-chair, infectious disease work group); Edward A. Feaver, Deputy Director for Health, Florida Department of Health and Rehabilitative Services (co-chair, infectious disease work group); and N. Mark Richards, M.D., Secretary of Health, Pennsylvania Department of Health (injury control/environmental health work group), whose leadership ensured the successful completion of the task at hand.

We are also indebted to the the Data Policy Review Panel; to our federal project officers, E. Jerry Spyke of the Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, and William Christoffel of the Bureau of Maternal and Child Health and Resources Development, Health Resources and Services Administration; and to George K. Degnon, ASTHO Executive Director, for their support and guidance.

Data collected through the revised system will be available beginning in 1991. Suggestions and comments on the enclosed materials and the full scope of the Foundation's new data set are invited. Address communications to Public Health Foundation, 1220 L Street, N.W., Washington, DC 20005.

James T. Dimas
Executive Director

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List of Participants

INTRODUCTION

The Public Health Foundation began revising its core data set in February 1989 by convening a work group of health data experts to redefine the purpose of the ASTHO Reporting System and to develop a conceptual framework for redesigning the core data set. The problem was clear. The existing system was driven by the need to be comprehensive. It therefore collected bits of data on the gamut of activities conducted by state and local health departments. As a result, the system lacked focus and the data were not as useful as they could have been. The group recommended that the new data set focus on high-priority public health problems and what health departments are doing to alleviate them. The group selected nine broad public health goals as the initial focus of the new data set. The nine goals, encompassing many of the Year 2000 Objectives, are to:

- Reduce the incidence of infant mortality;
- Reduce the incidence of adolescent pregnancy;
- Prevent, detect, and control cancer;
- Prevent, detect, and control cardiovascular diseases;
- Prevent and control AIDS and HIV infection;
- Prevent and control sexually transmitted diseases;
- Prevent and control vaccine-preventable diseases;
- Reduce and control injuries; and
- Reduce environmental public health hazards.

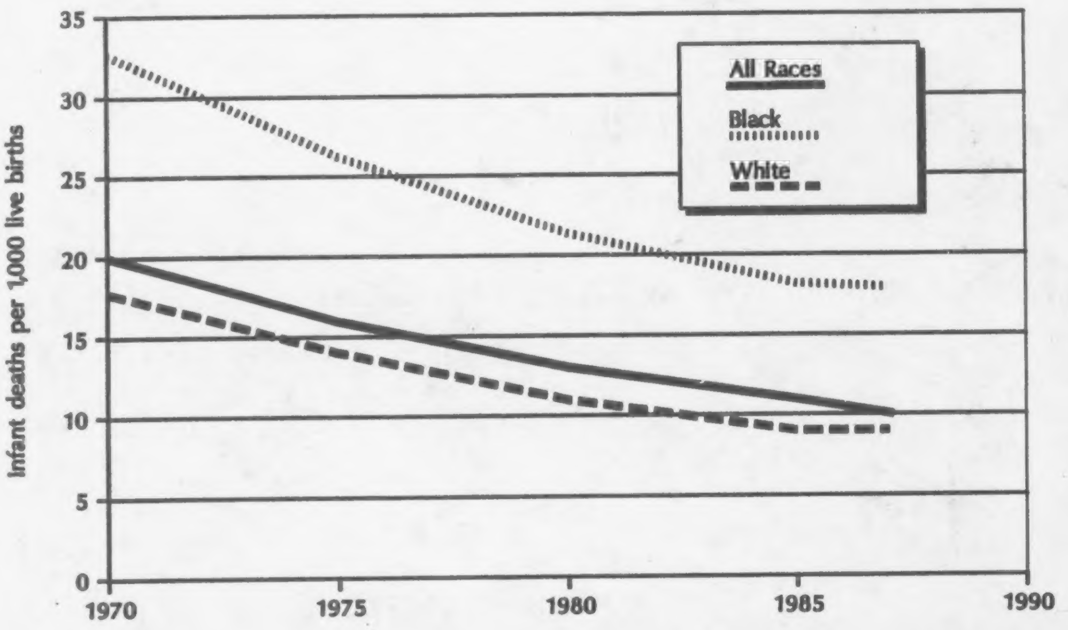
Four work groups met in January 1990 to begin revising the core data set. The work groups were composed of state and local health officers, and state and federal program directors and statisticians, and included representatives from 23 state health agencies, six local health departments, and five federal agencies. Following a seven-step design process, the groups developed a data set for each of the nine goals. As part of the process, the work groups created more than 400 graphic outputs that display significant indicators of health status. The groups also ranked the indicators according to the impact of health department activities on desired health outcomes, and according to data availability. The work groups recommended for inclusion in the new core data set those graphics that best depict the impact public health departments are having on national health priorities, and for which data are readily available or for which data could be obtained with a modest investment of resources. Nearly one-third of the graphics reflect health outcome measures (e.g., infant mortality rates) that can be obtained from existing data sources such as the National Center for Health Statistics. The remaining data elements will be collected through the Public Health Foundation's ASTHO Reporting System.

In general, the new ASTHO Reporting System core data set will focus on health outcomes and health department activities which affect those outcomes. Each data set will be capable of depicting the magnitude of the public health problem and the health department interventions and resources that are directed toward alleviating the problem. The system will give Congress and state legislatures invaluable information about how health departments are working to achieve the Year 2000 Objectives.

The Foundation plans to implement the revised reporting system for the FY 1990 data cycle. Before the information is collected, staff will design and test the survey instruments and subject the proposed survey instruments to the Foundation's standard Data Policy Review System for new data requests. The information will be collected from state health agencies early in 1991. Data will be available beginning later that year.

Samples of graphics developed by the work groups follow. Some graphics display actual data while others contain mock data for illustration purposes.

FIGURE 1.
U.S. INFANT MORTALITY RATES, BY RACE, 1970-1987



Source: National Center for Health Statistics

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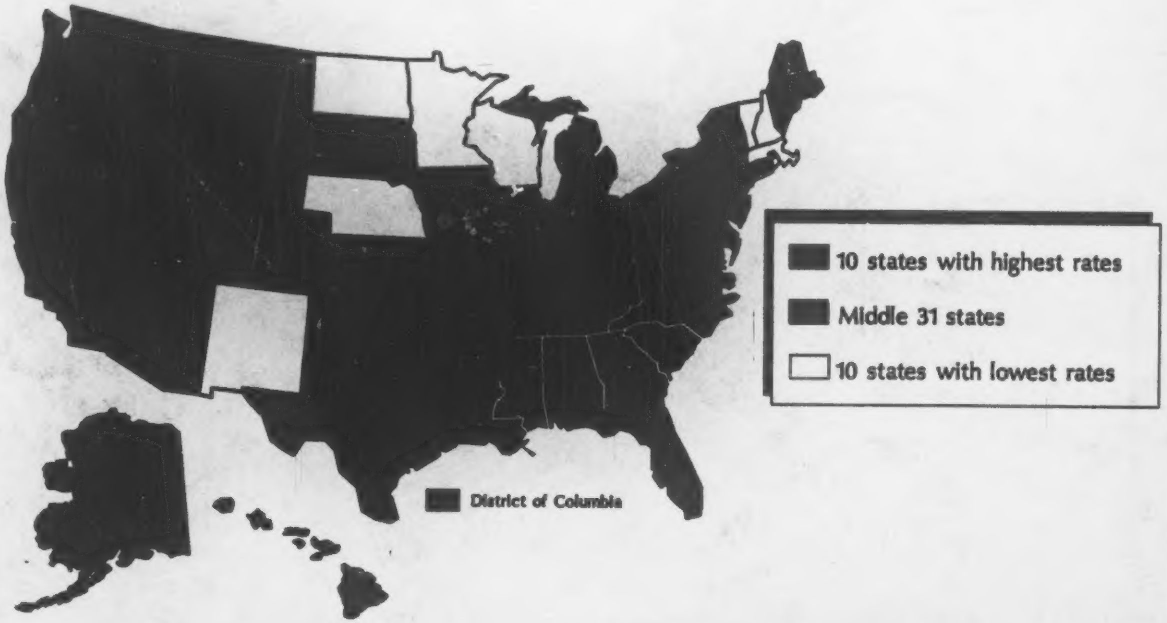
FIGURE 2.
INFANT MORTALITY RATES, 1987


▇ 10 states with highest rates
▇ Middle 31 states
☐ 10 states with lowest rates
▇ District of Columbia

Source: National Center for Health Statistics

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FIGURE 3.
STATES CONDUCTING STATE, REGIONAL, OR LOCAL ANNUAL INFANT DEATH REVIEW

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

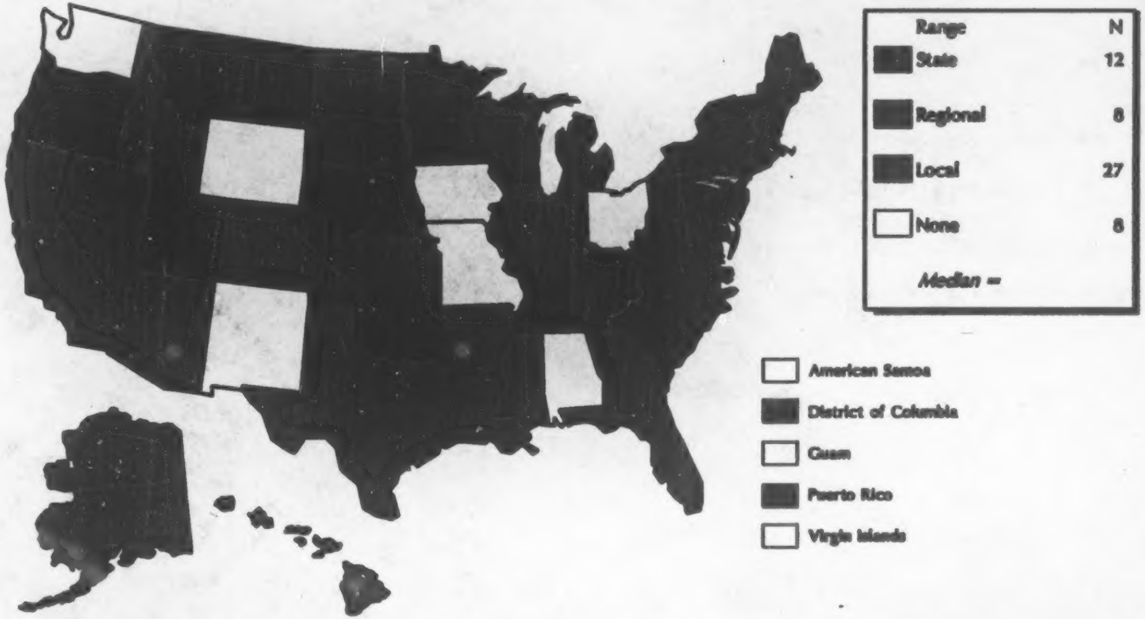
Range
N
State
12
Regional
8
Local
27
None
8
Median =
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

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FIGURE 4.
COUNTIES WITHOUT HEALTH DEPARTMENT PRENATAL CARE SERVICES

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

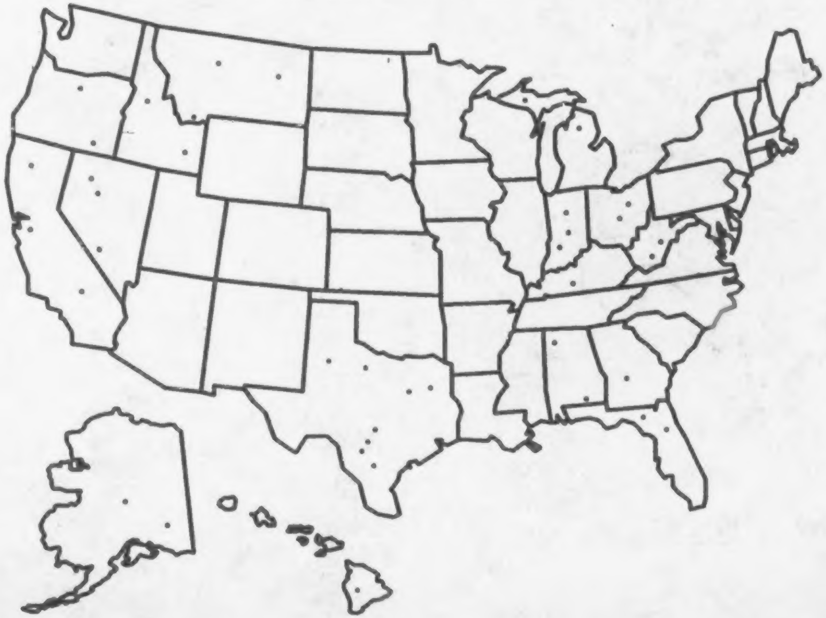

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FIGURE 5.
COUNTIES THAT ARE MEDICALLY UNDERSERVED IN OBSTETRICS

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

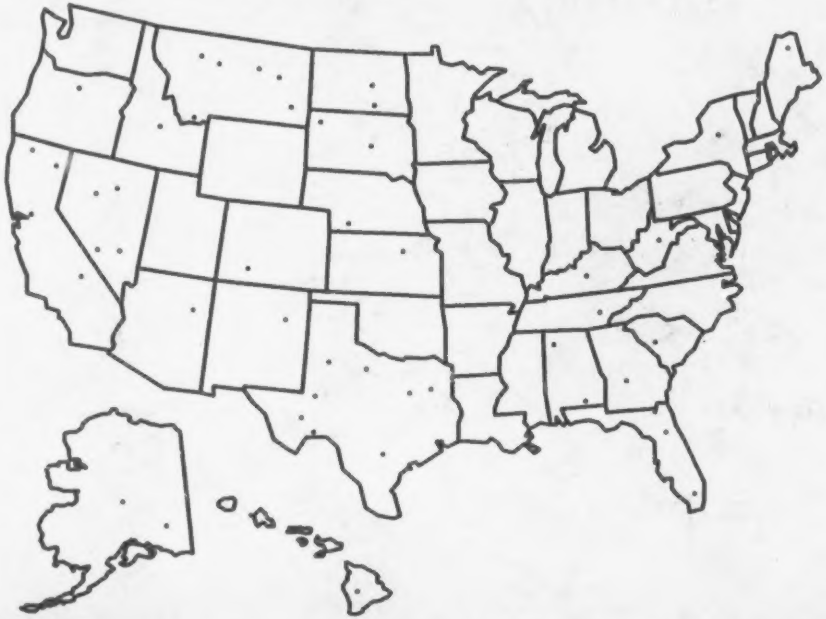

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FIGURE 6.
PERCENTAGE OF PREGNANT WOMEN SMOKING AT LEAST 10 CIGARETTES PER DAY

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

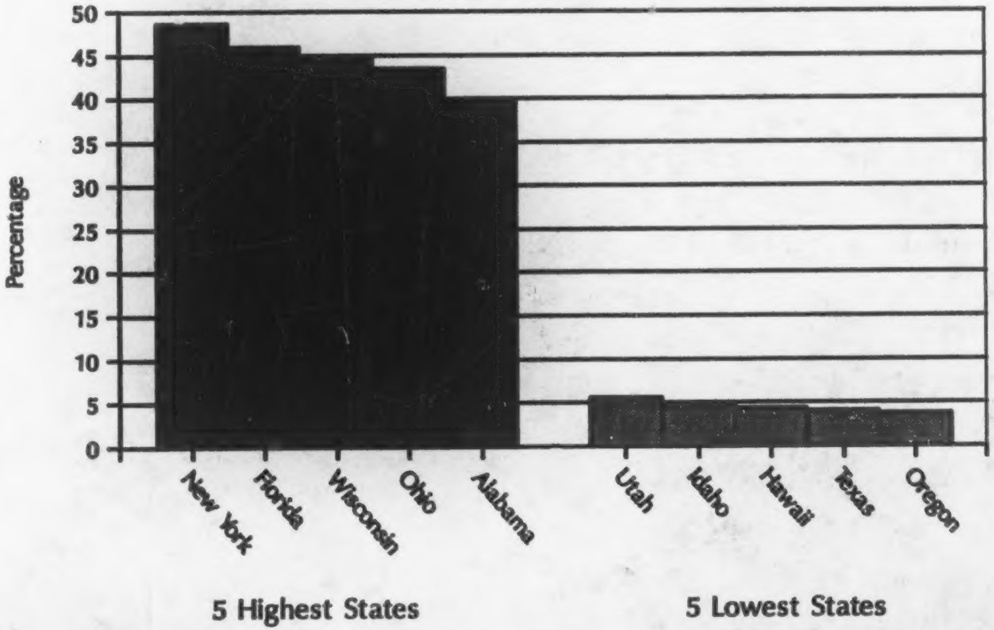

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FIGURE 7.
PERCENTAGE OF ADOLESCENTS IN NEED SERVED BY FAMILY PLANNING PROGRAMS

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

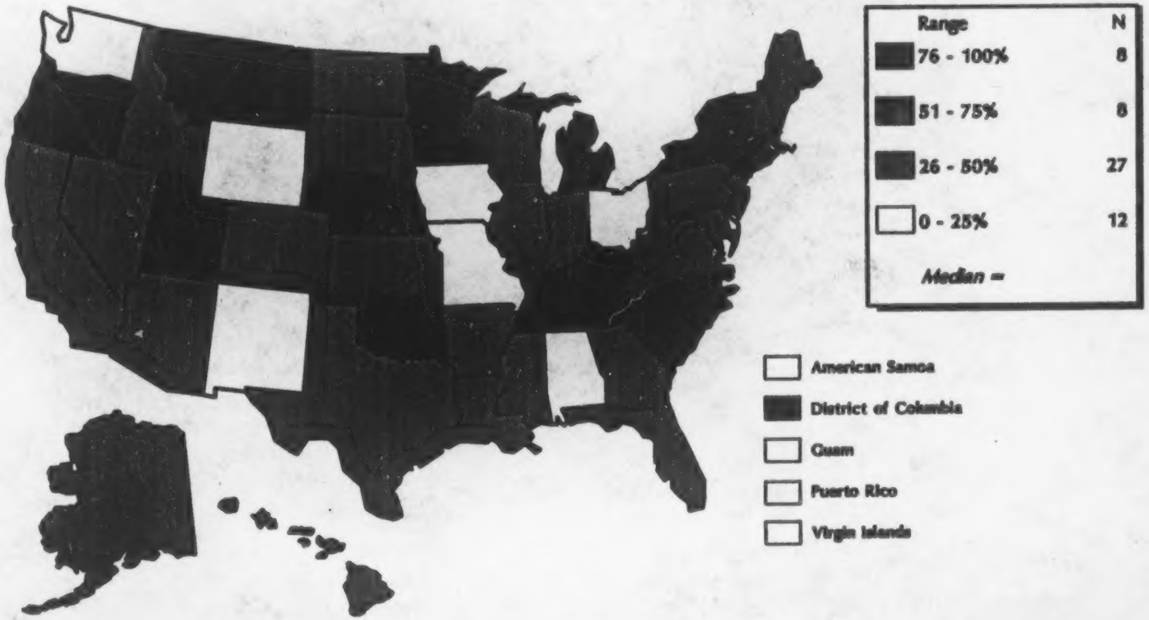
Range
N
76 - 100%
8
51 - 75%
8
26 - 50%
27
0 - 25%
12
Median =
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

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FIGURE 8.
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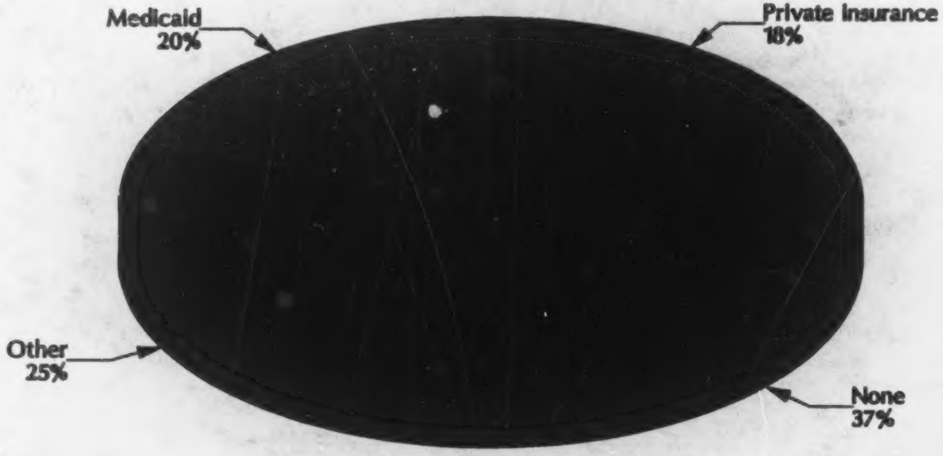
BY SOURCE OF PAYMENT

NOTE: THIS GRAPHIC CONTAINS MOCK DATA



TOTAL:

FIGURE 9.
PERCENTAGE OF ADOLESCENT MOTHERS WHO GO OFF AFDC WITHIN 'X' TIME OF COMPLETING JOB TRAINING

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

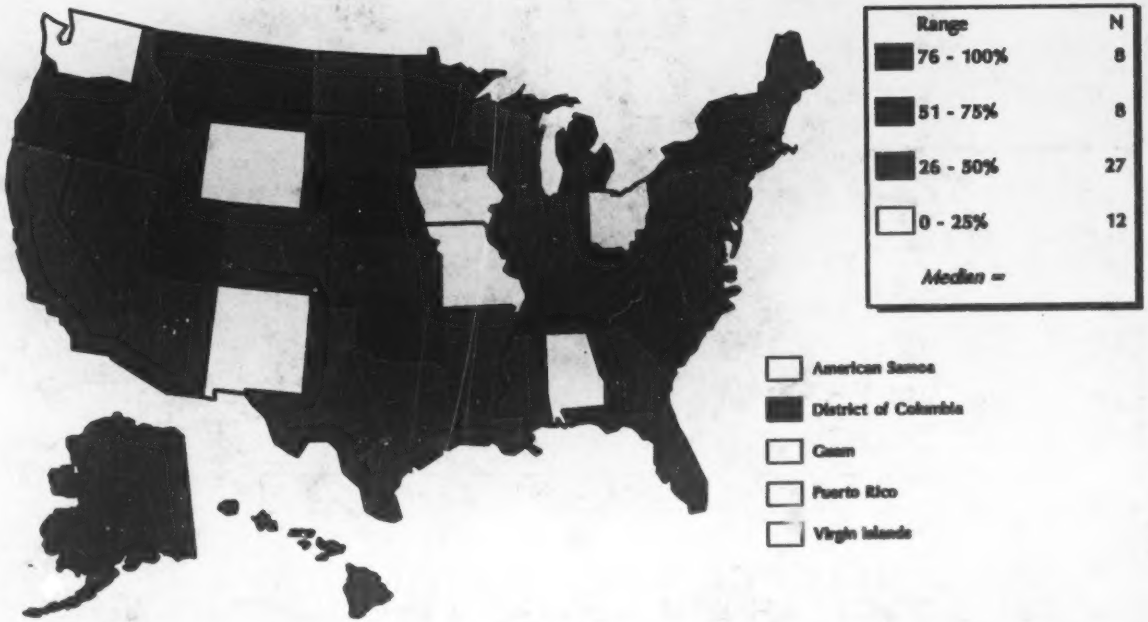

Range
N
76 - 100%
8
51 - 75%
8
26 - 50%
27
0 - 25%
12
Median =
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

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FIGURE 10.
PERCENTAGE OF SCHOOL DISTRICTS THAT HAVE IMPLEMENTED FAMILY LIFE CURRICULUM IN GRADES K-12

NOTE: THIS GRAPHIC CONTAI[illegible]OCK DATA

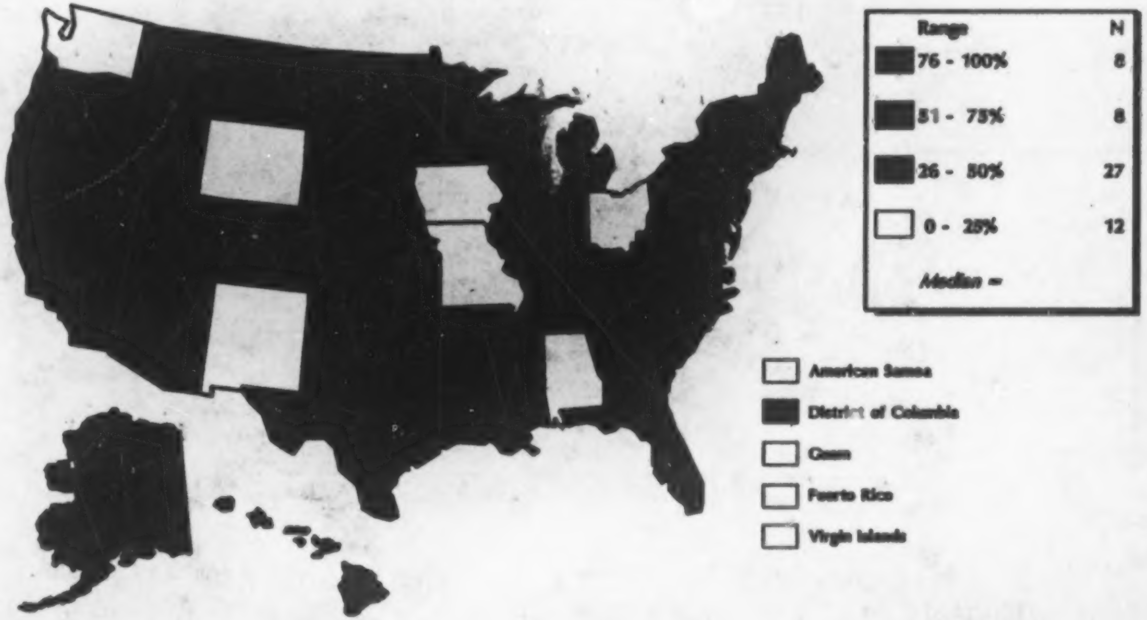
Range
N
76 - 100%
8
51 - 75%
8
26 - 50%
27
0 - 25%
12
Median =
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

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FIGURE 11.
STATES UTILIZING AN ADOLESCENT RISK ASSESSMENT TOOL

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

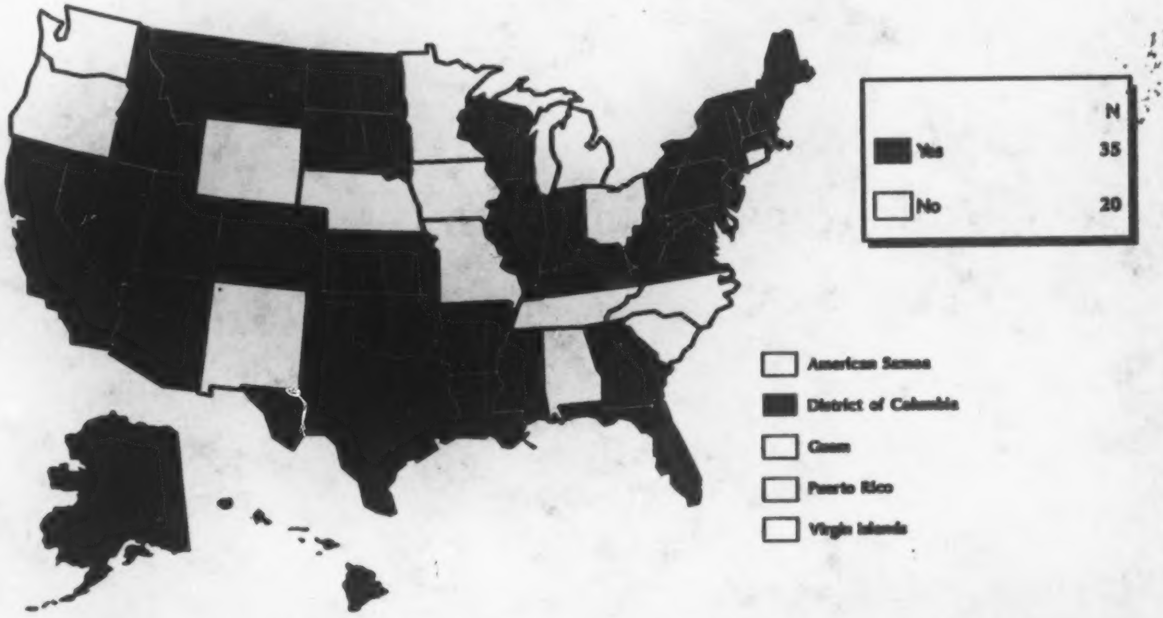
N
Yes 35
No 20
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

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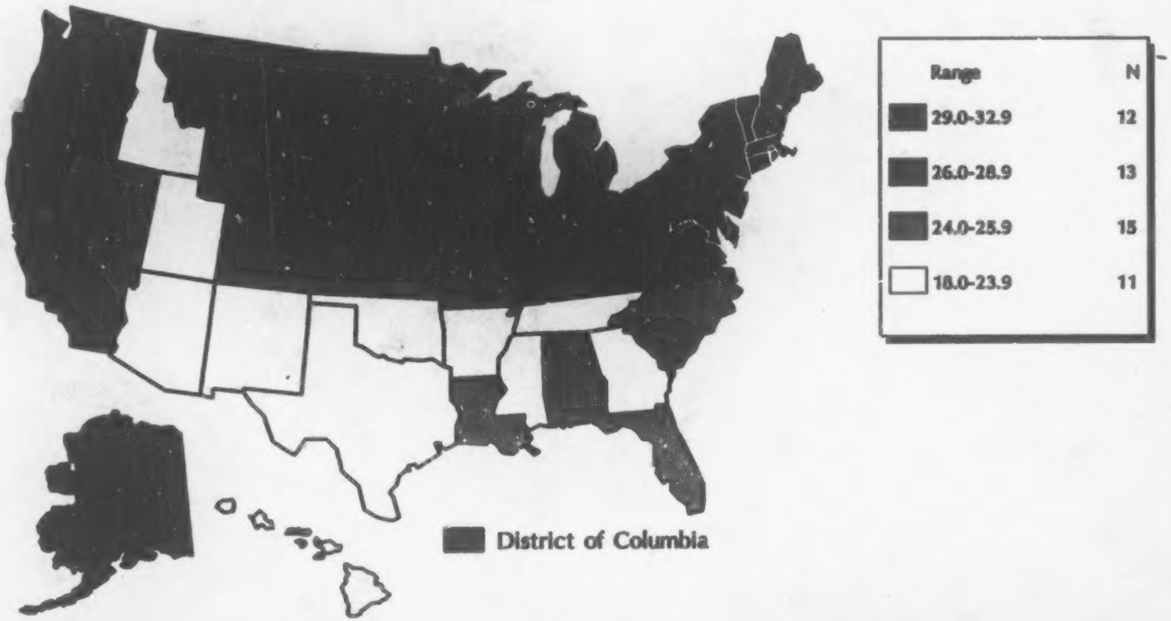
FIGURE 12.
AVERAGE ANNUAL AGE-ADJUSTED BREAST CANCER MORTALITY,
PER 100,000 WOMEN, 1982-1986


Range
N
29.0-32.9
12
26.0-28.9
13
24.0-25.9
15
18.0-23.9
11
District of Columbia

Source: National Cancer Institute

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FIGURE 13.
PERCENTAGE OF WOMEN AGED 40 AND OVER SCREENED FOR BREAST CANCER WITHIN THE LAST TWO YEARS, BY RACE AND BY TYPE OF SCREENING

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

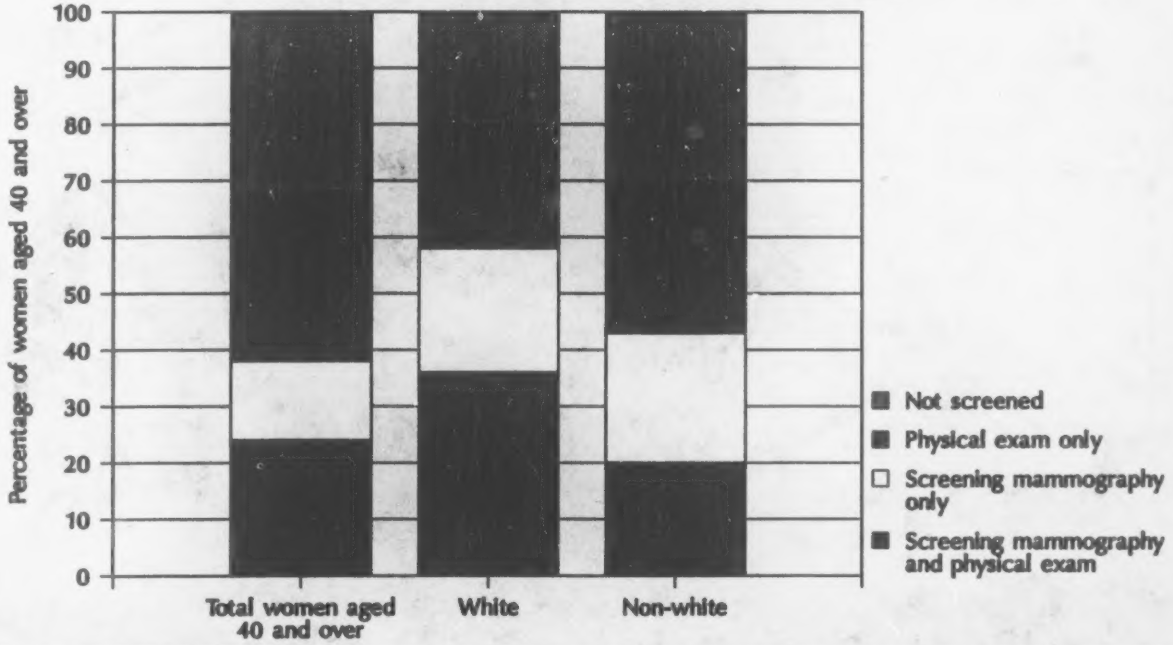

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FIGURE 14.
STATES MANDATING COVERAGE FOR SCREENING MAMMOGRAPHY

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

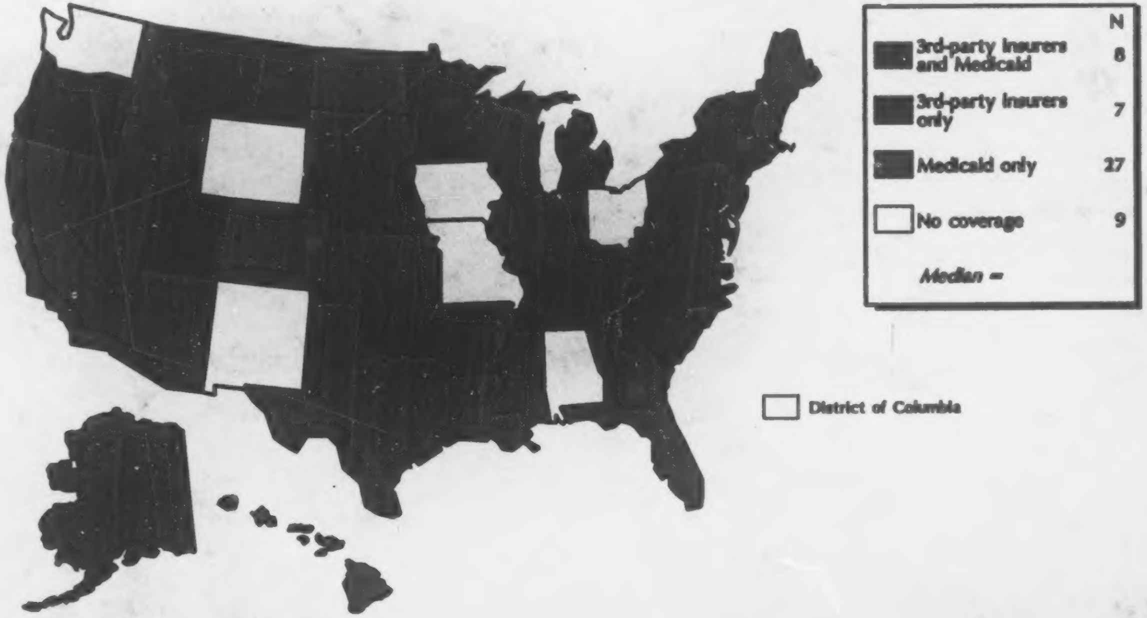
N
3rd-party insurers and Medicaid 8
3rd-party insurers only 7
Medicaid only 27
No coverage 9
Median =
District of Columbia

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FIGURE 15.
STATES WITH REDUCED-PRICE PROGRAMS FOR SCREENING MAMMOGRAPHY

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

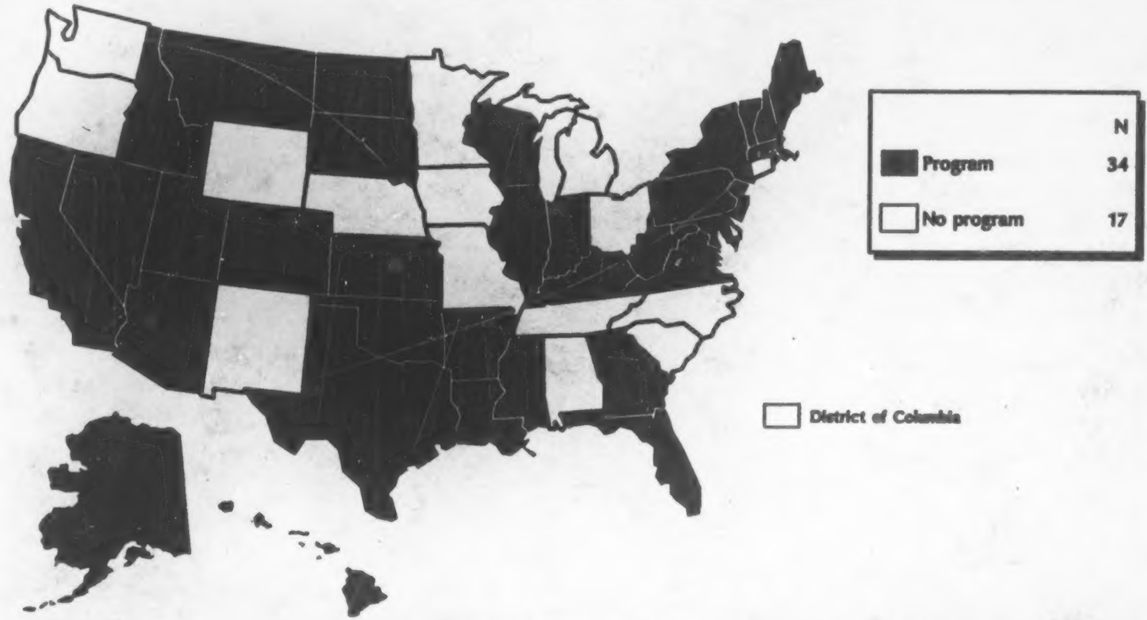
N
Program 34
No program 17
District of Columbia

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FIGURE 16.
SMOKING PREVALENCE, 1970-1990

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

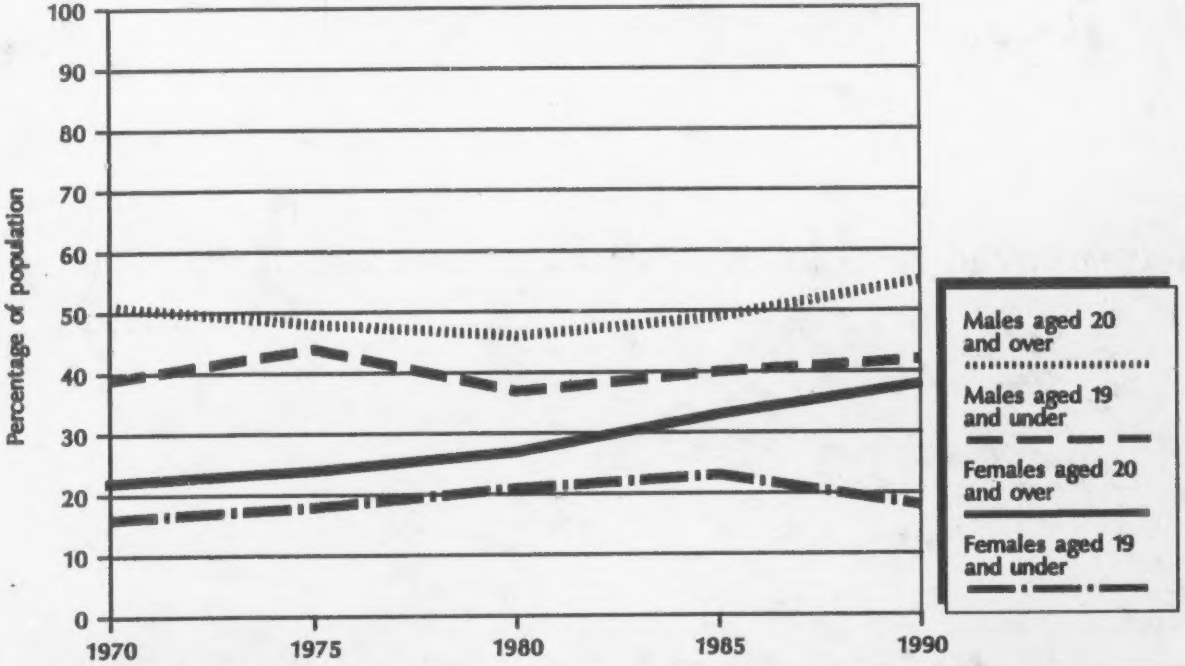

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FIGURE 17.
CORONARY HEART DISEASE MORTALITY RATES
FOR PERSONS AGED 40-64, 1970-1990

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

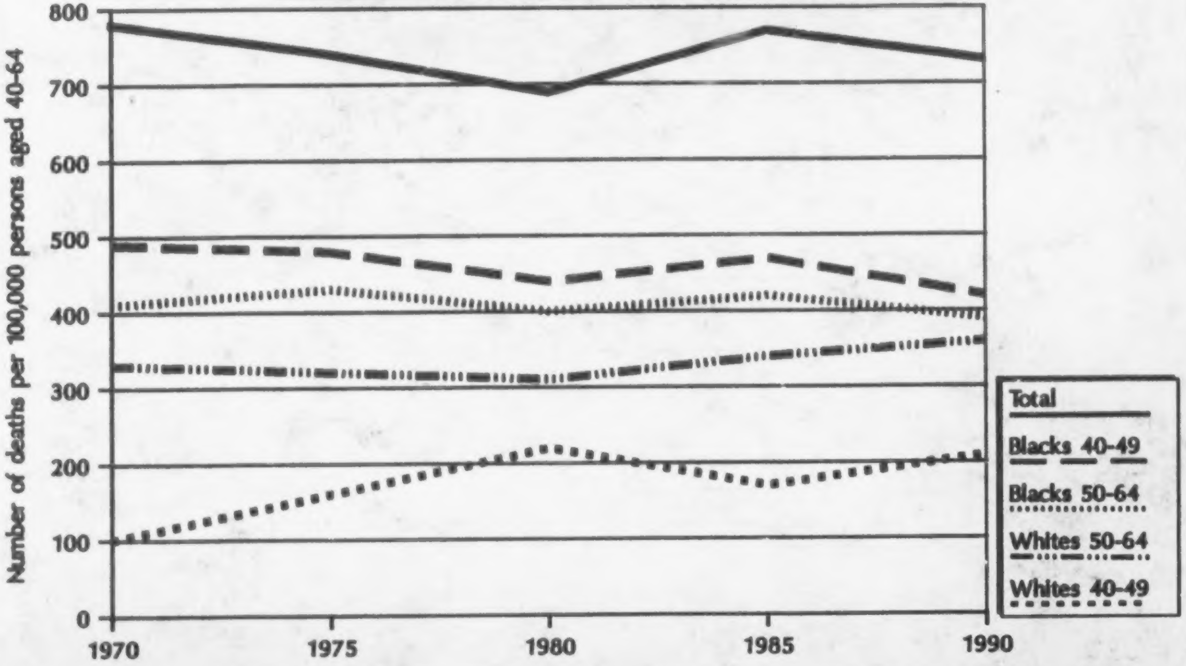

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FIGURE 18.
PERCENTAGE OF PERSONS AGED 18 AND OVER WITH HIGH BLOOD PRESSURE NOT UNDER CARE, 1970-1990

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

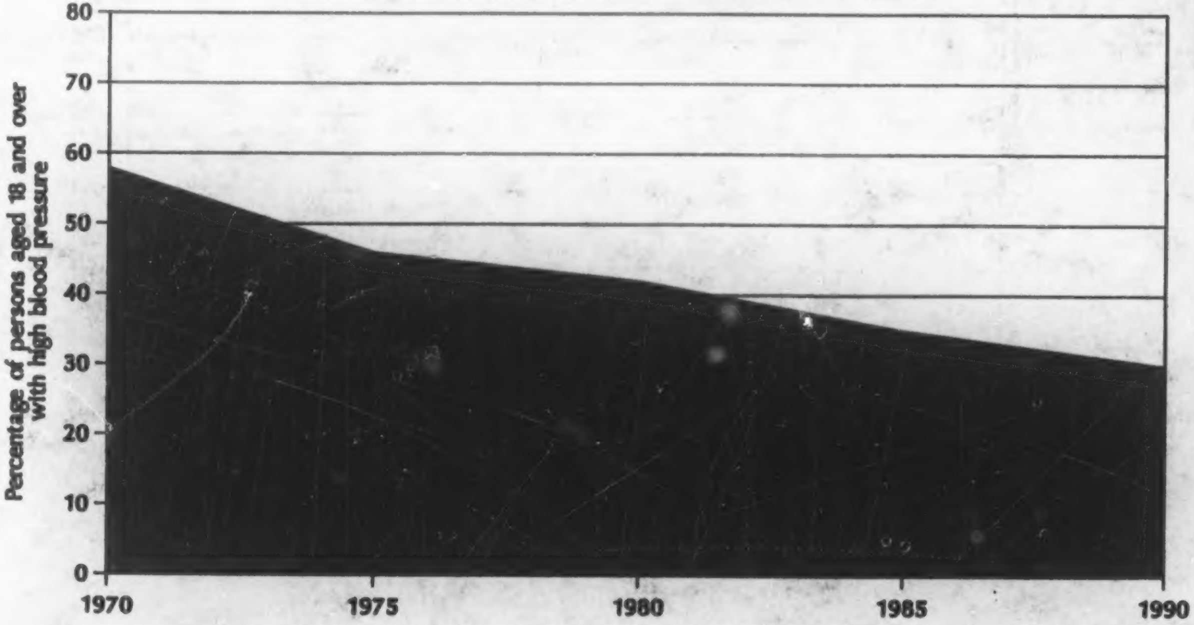

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FIGURE 19.
PERCENTAGE OF POPULATION COUNSELED BY A HEALTH CARE PROVIDER ABOUT SELECTED RISK FACTORS FOR CARDIOVASCULAR DISEASE, 1970-1990

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

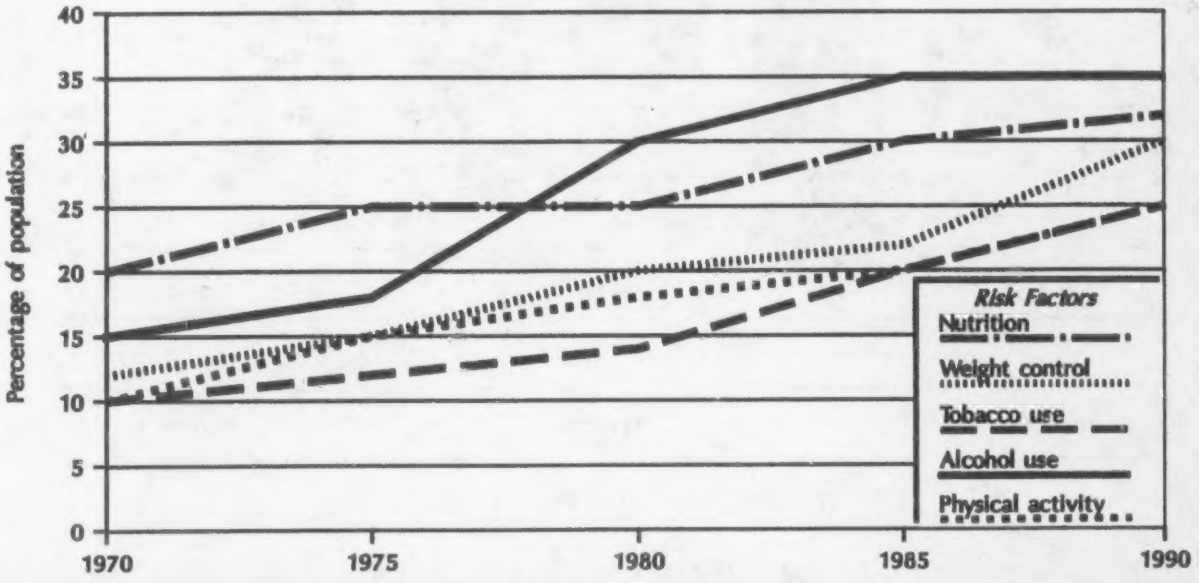

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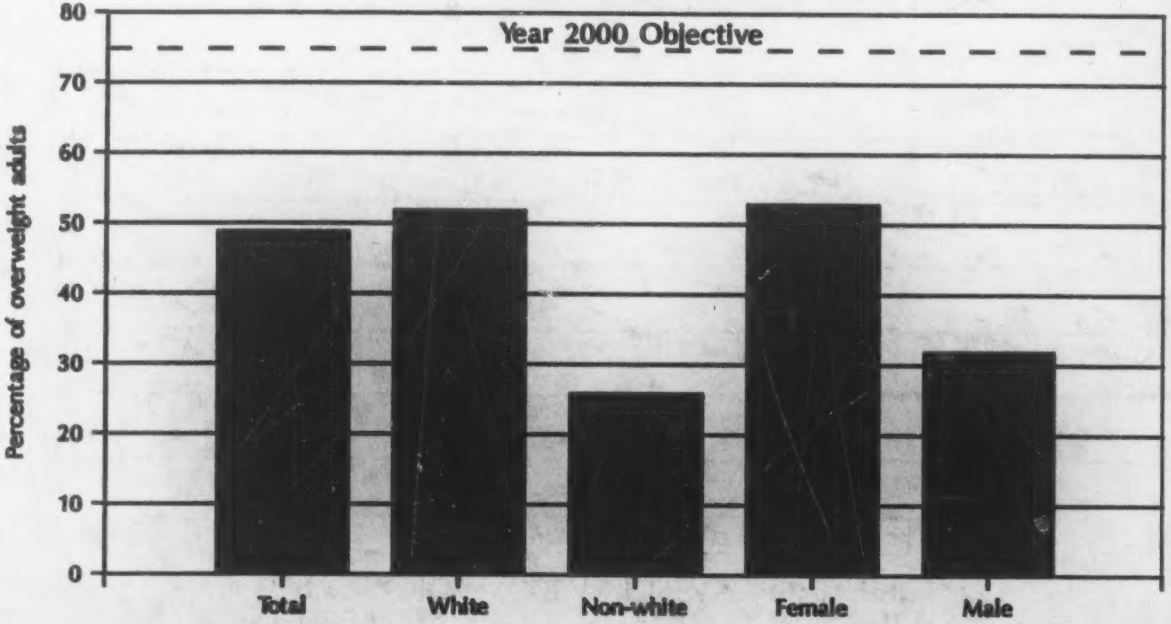
FIGURE 20.
PERCENTAGE OF OVERWEIGHT ADULTS TRYING TO LOSE WEIGHT, 1990*

NOTE: *THIS GRAPHIC CONTAINS MOCK DATA*



* Those who combine sound dietary practices with physical activity to achieve weight reduction.

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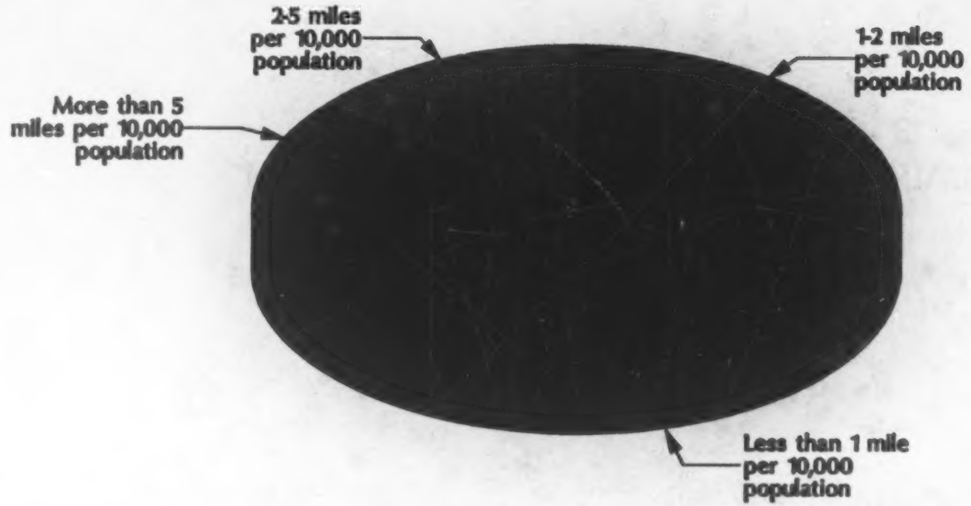
FIGURE 21.
WALKING TRAILS IN CITIES WITH POPULATIONS GREATER THAN 25,000

NOTE: THIS GRAPHIC CONTAINS MOCK DATA



Year 2000 Objective is 1 mile per 10,000 population

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FIGURE 22.
NUMBER OF NEW AIDS CASES,
BY REPORTED RISK GROUP, 1982-1988

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

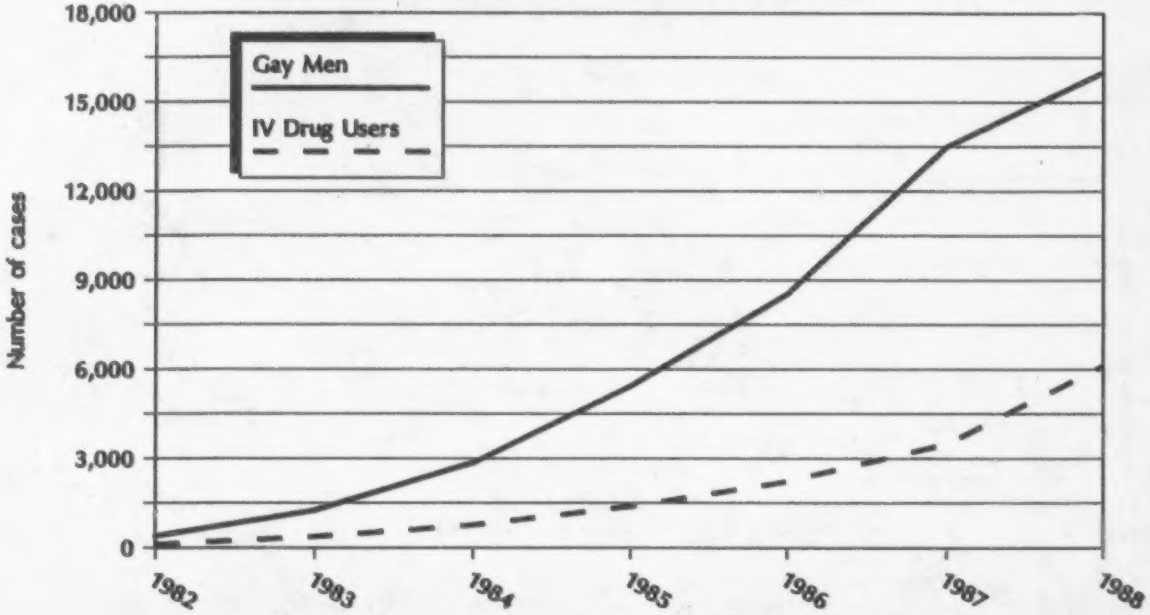

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FIGURE 23.
STATES WITH MANDATORY REPORTING OF HIV POSITIVES BY NAME AND/OR BY CASE NUMBER

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

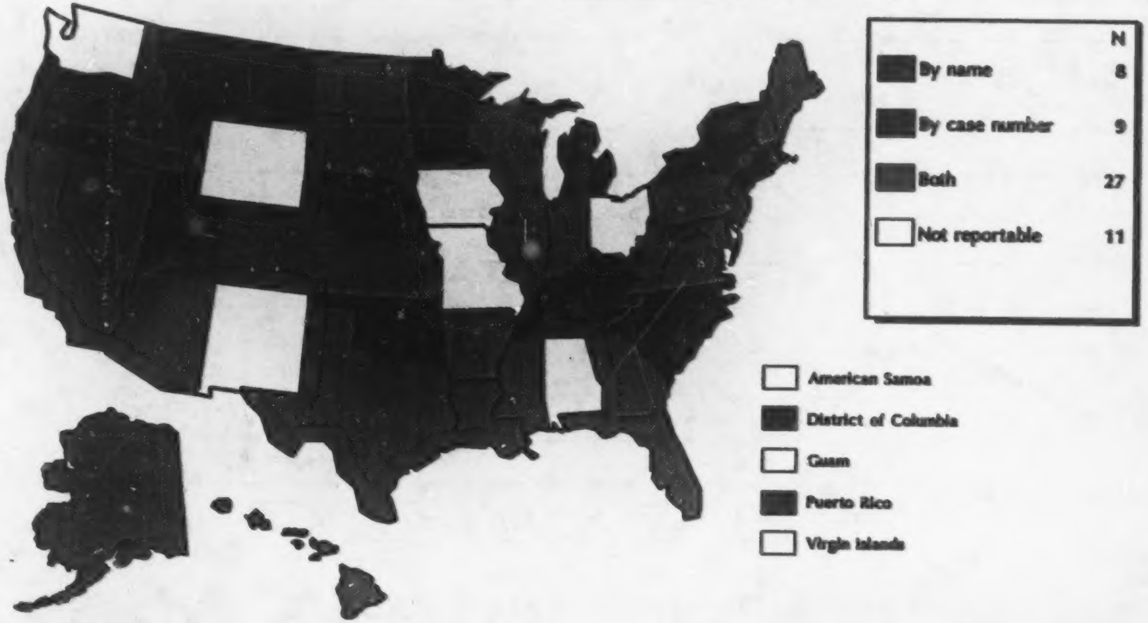
N
By name 8
By case number 9
Both 27
Not reportable 11
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

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FIGURE 24.
STATES PROVIDING PUBLICLY-FUNDED AZT TREATMENT
OR COVERING AZT TREATMENT THROUGH MEDICAID AGENCY

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

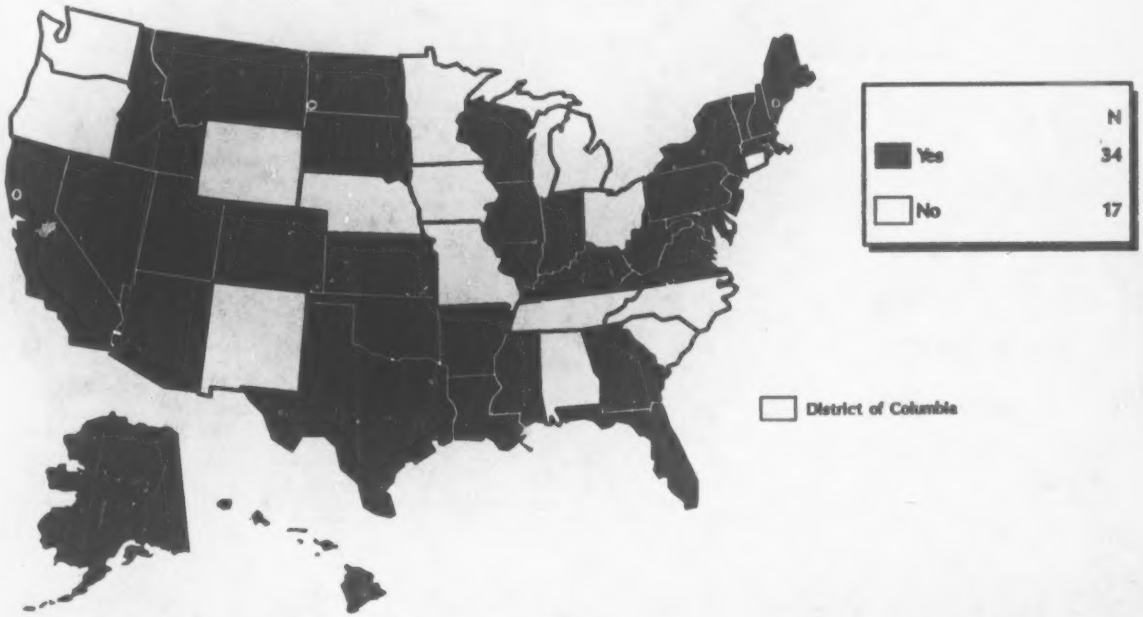
N
Yes 34
No 17
District of Columbia

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FIGURE 25.
METHODS OF HIV PARTNER NOTIFICATION USED BY STATES

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

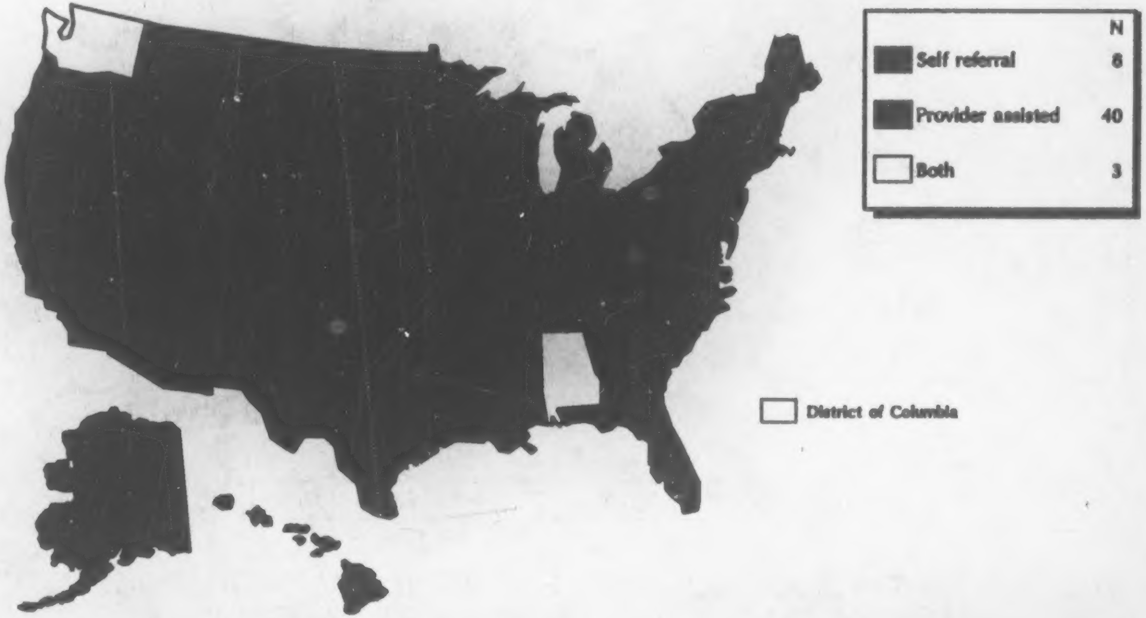
N
Self referral 8
Provider assisted 40
Both 3
District of Columbia

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FIGURE 26.
PERCENTAGE OF DRUG-ABUSING PREGNANT WOMEN ENTERING TREATMENT PROGRAM WITHIN ONE WEEK OF APPLYING

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

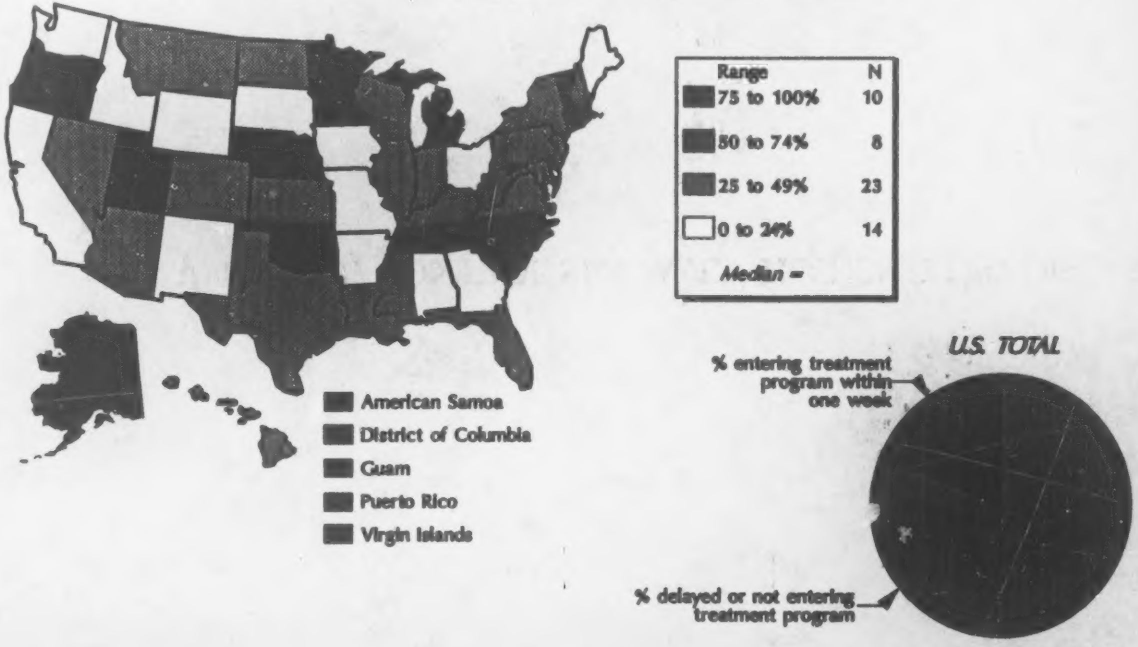
Range N
75 to 100% 10
50 to 74% 8
25 to 49% 23
0 to 24% 14
Median =
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands
U.S. TOTAL
% entering treatment program within one week
% delayed or not entering treatment program

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FIGURE 27.
GONORRHEA INCIDENCE RATE, COMPARED TO YEAR 2000 OBJECTIVE

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

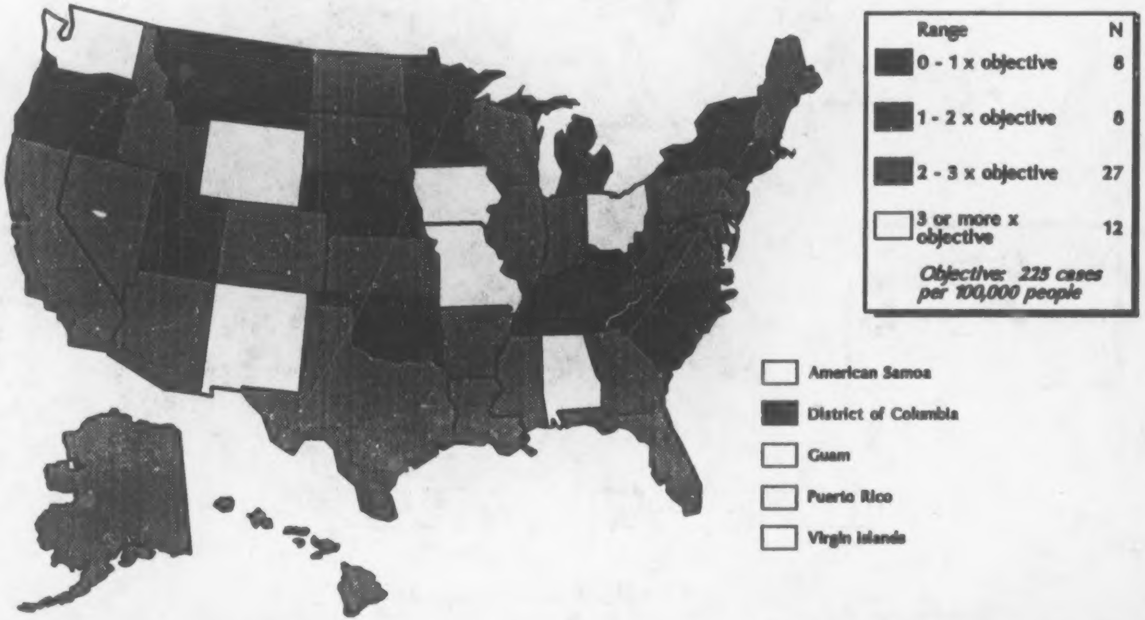
Range
N
0 - 1 x objective 8
1 - 2 x objective 8
2 - 3 x objective 27
3 or more x objective 12
Objective: 225 cases per 100,000 people
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

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FIGURE 28.
STATES REQUIRING PERINATAL SEROLOGY FOR SYPHILIS
AT TIME OF DELIVERY

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

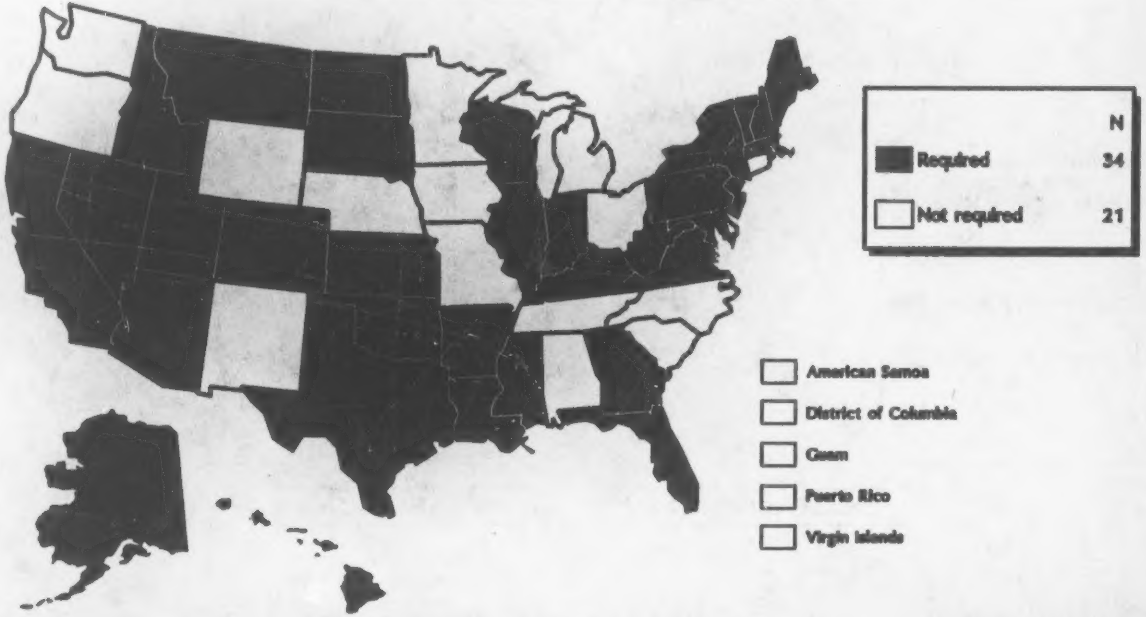
N
Required 34
Not required 21
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

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FIGURE 29.
TOTAL NUMBER OF PARTNERS OF STD CASES IDENTIFIED AND NUMBER TREATED, BY DISEASE

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

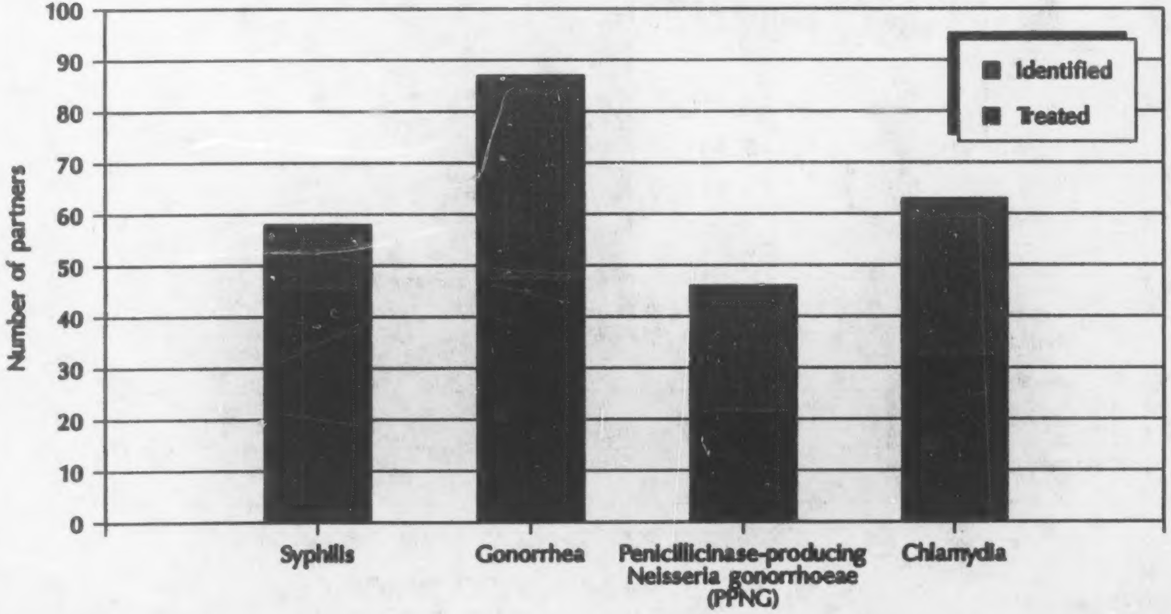
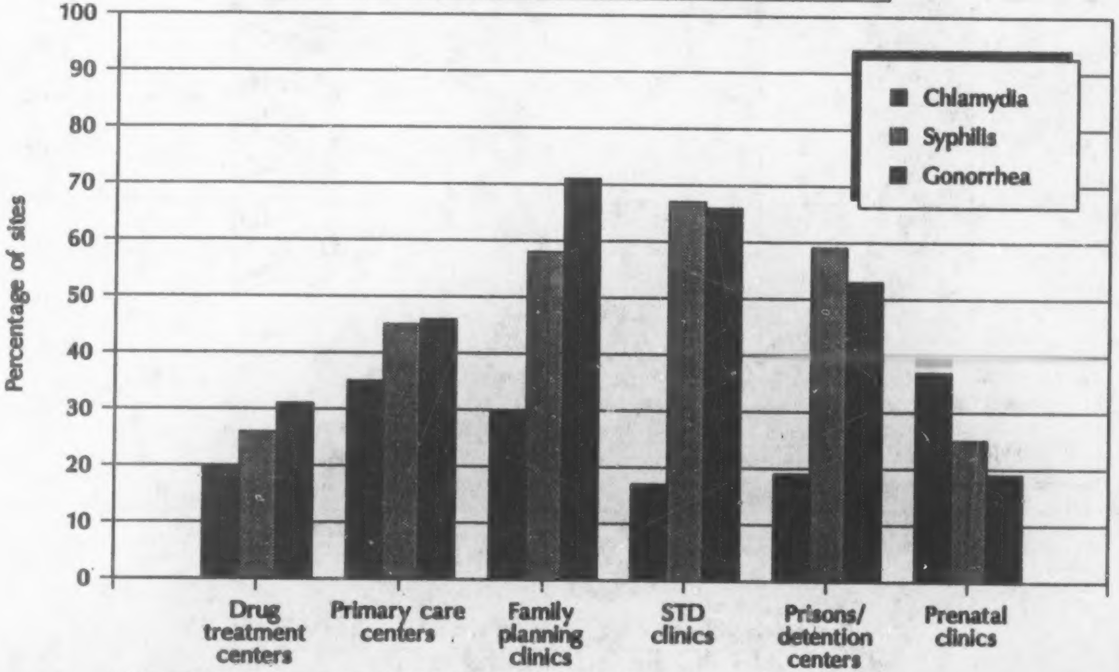


FIGURE 30.
PERCENTAGE OF PUBLICLY-FUNDED SITES PROVIDING COMPREHENSIVE STD SERVICES*

NOTE: *THIS GRAPHIC CONTAINS MOCK DATA*



*Sites providing STD screening, clinical, and follow-up services.

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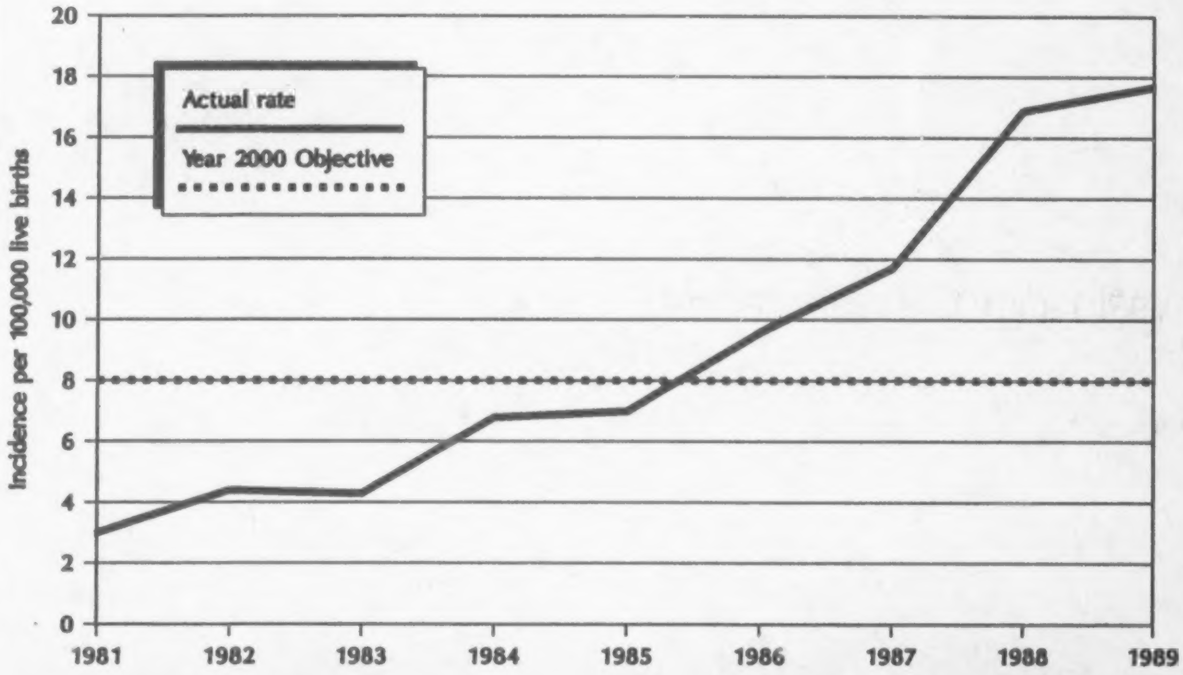
FIGURE 31.
CONGENITAL SYPHILIS INCIDENCE RATE, 1981-1989



Source: Centers for Disease Control

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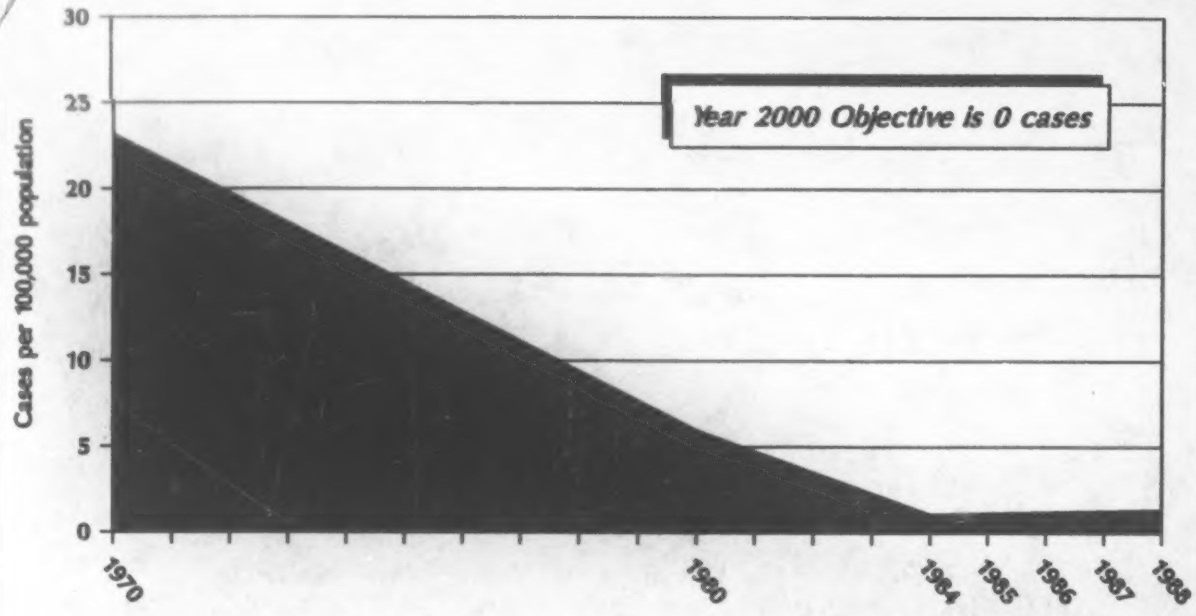
FIGURE 32.
NUMBER OF CASES OF MEASLES PER 100,000 U.S. POPULATION, 1970-1988



Source: Centers for Disease Control

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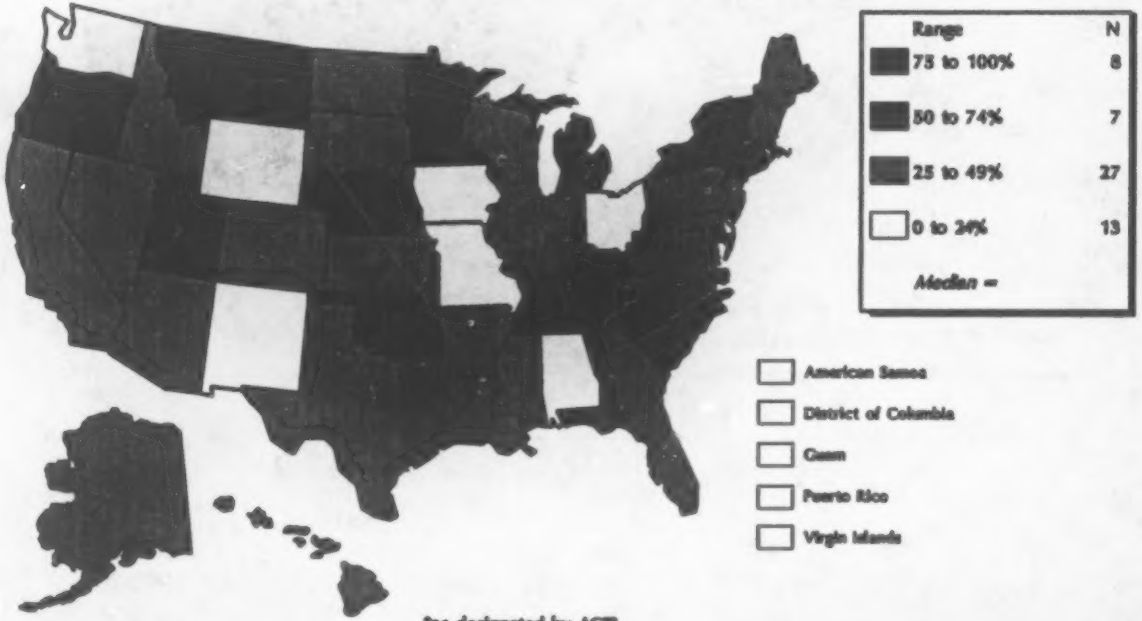
FIGURE 33.
PERCENTAGE OF DESIGNATED TARGET POPULATION* IMMUNIZED AGAINST MEASLES WITH PUBLICLY-FUNDED DOSES

NOTE: *THIS GRAPHIC CONTAINS MOCK DATA*


Range
N
75 to 100%
8
50 to 74%
7
25 to 49%
27
0 to 24%
13
Median =
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

*as designated by ACIP

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FIGURE 34.
NUMBER OF OUTBREAKS INVESTIGATED AND NUMBER OF OUTBREAKS CONTROLLED WITHIN 3 GENERATIONS, BY DISEASE

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

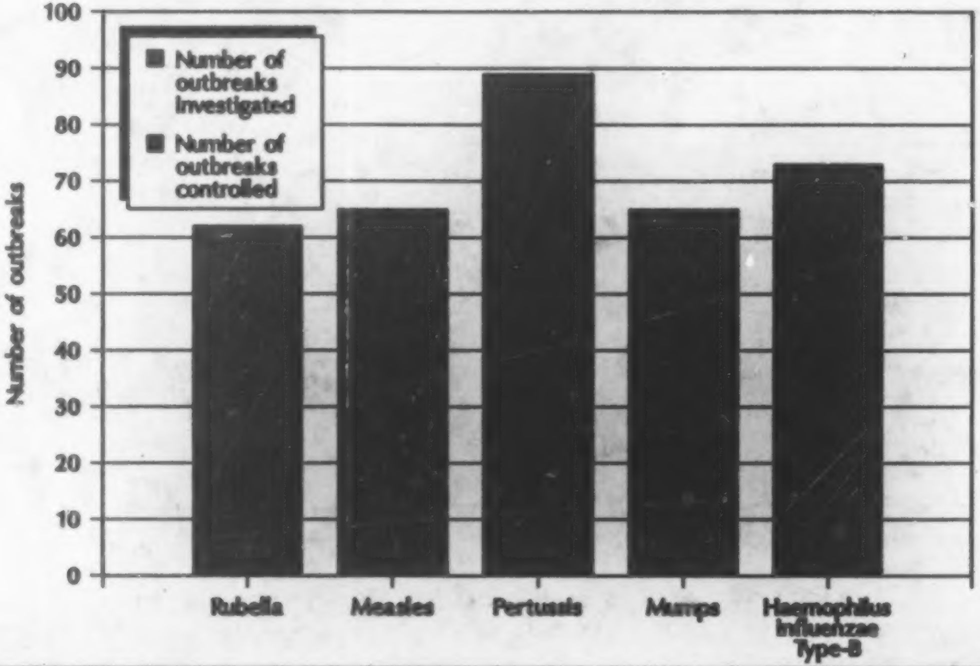

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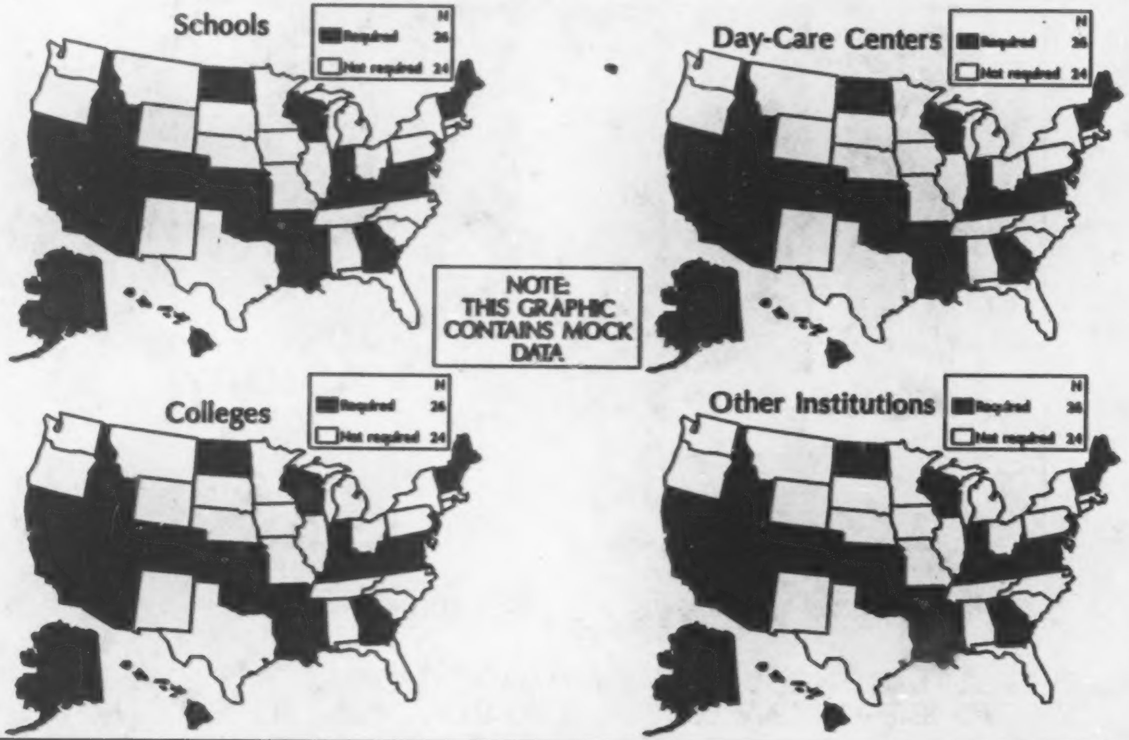
FIGURE 35.
STATES REQUIRING IMMUNIZATION FOR ENTRY INTO SCHOOLS, DAY-CARE CENTERS, COLLEGES, AND OTHER INSTITUTIONS


Schools
N
Required 26
Not required 24
Day-Care Centers
N
Required 26
Not required 24
Colleges
N
Required 26
Not required 24
Other Institutions
N
Required 26
Not required 24

NOTE:
THIS GRAPHIC
CONTAINS MOCK
DATA

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FIGURE 36.
STATE HEALTH AGENCIES PROVIDING HEPATITIS-B IMMUNIZATIONS TO SUSCEPTIBLE NEWBORNS OF HEPATITIS-B MOTHERS

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

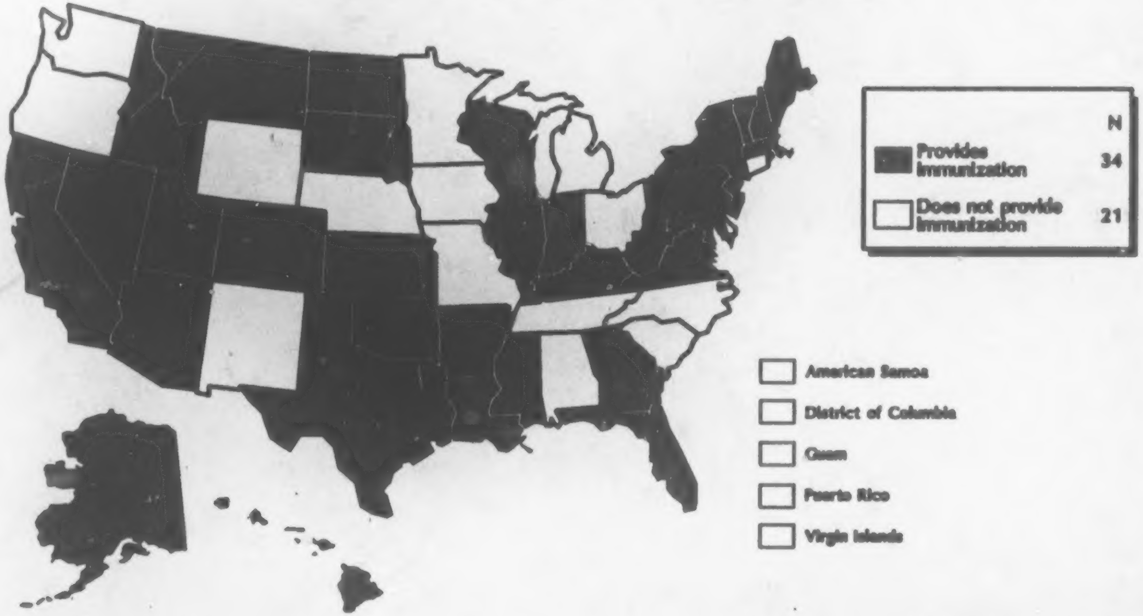
N
▇ Provides Immunization 34
☐ Does not provide Immunization 21
☐ American Samoa
☐ District of Columbia
☐ Guam
☐ Puerto Rico
☐ Virgin Islands

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FIGURE 37.
NUMBER OF STATES COLLECTING INJURY DATA,
BY TYPE OF INJURY AND DATA SOURCE, 1990-1991

NOTE: *THIS GRAPHIC CONTAINS MOCK DATA*

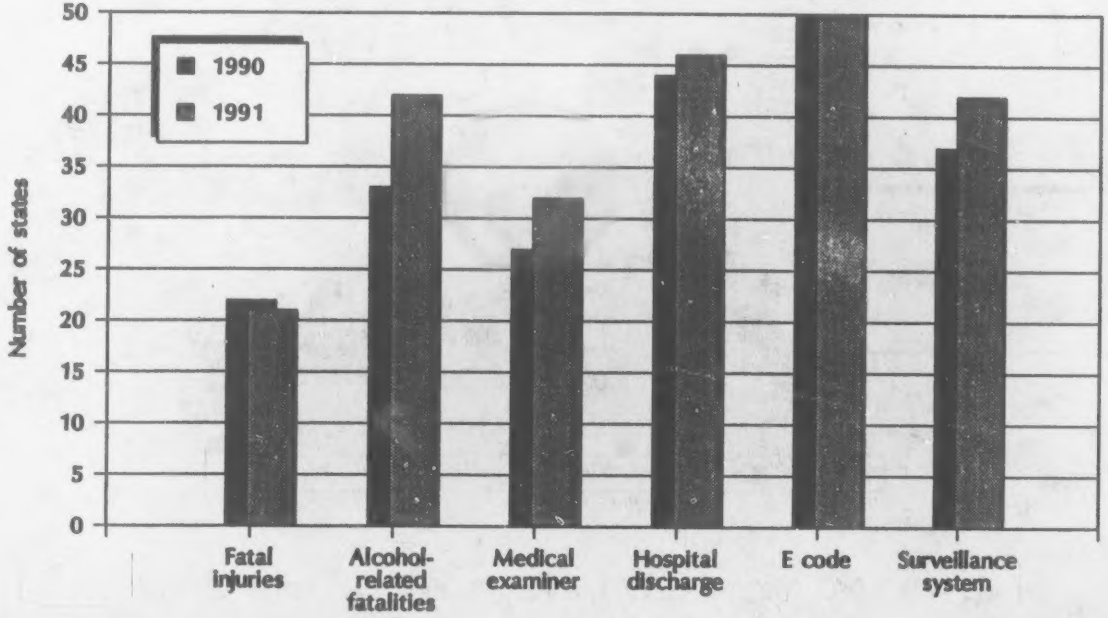

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FIGURE 38.
STATES ABLE TO LINK HAZARD AND INJURY DATA BASES

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

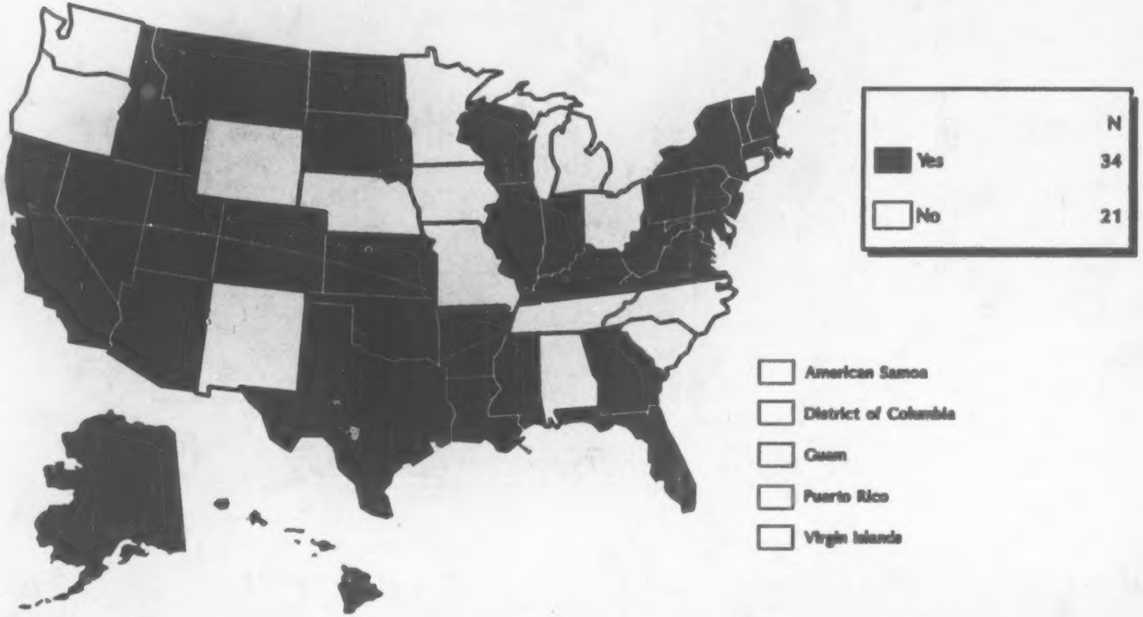
N
Yes 34
No 21
American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands

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FIGURE 39.
SEAT BELT USAGE AND MOTOR VEHICLE CRASH MORTALITY IN 29 STATES WITH MANDATORY SEAT BELT LAWS, 1987-1990

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

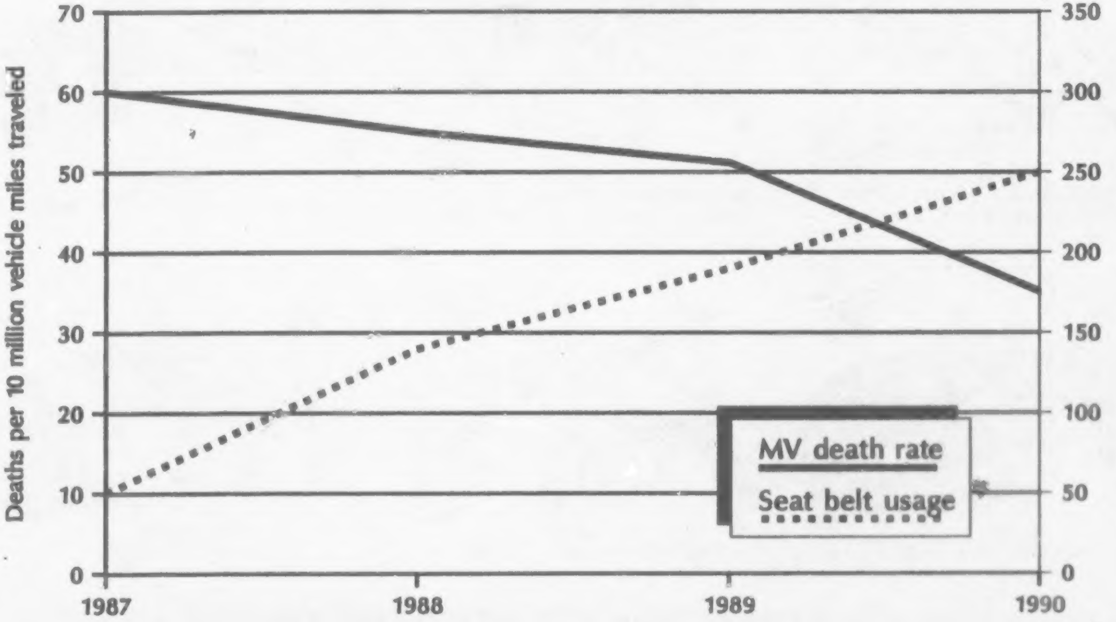

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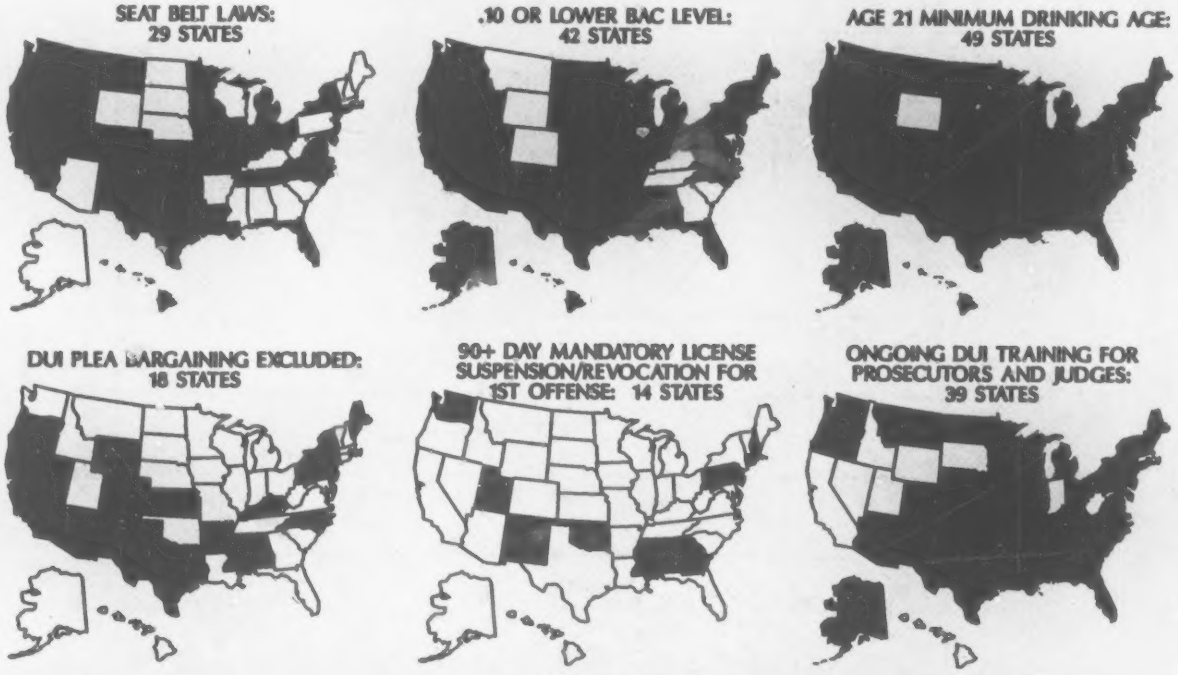
FIGURE 40.
STATES WITH LEGISLATION TO REDUCE
ALCOHOL-RELATED MOTOR VEHICLE CRASHES, 1987



SEAT BELT LAWS:
29 STATES

.10 OR LOWER BAC LEVEL:
42 STATES

AGE 21 MINIMUM DRINKING AGE:
49 STATES

DUI PLEA BARGAINING EXCLUDED:
18 STATES

90+ DAY MANDATORY LICENSE
SUSPENSION/REVOCATION FOR
1ST OFFENSE: 14 STATES

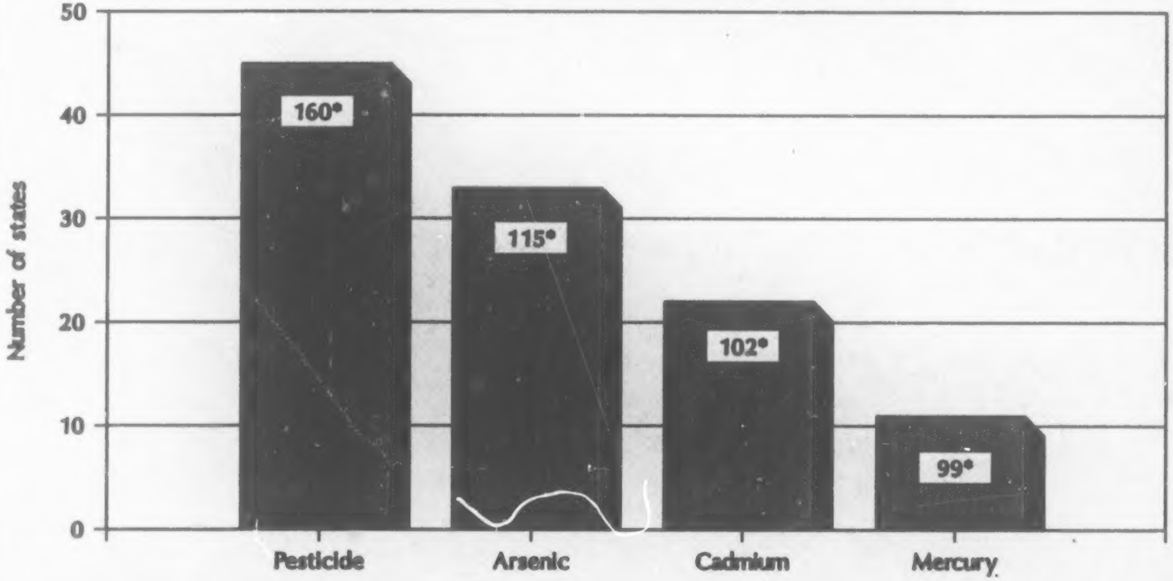
ONGOING DUI TRAINING FOR
PROSECUTORS AND JUDGES:
39 STATES

Source: National Commission Against Drunk Driving

REDUCE ENVIRONMENTAL PUBLIC HEALTH HAZARDS

FIGURE 41.
NUMBER OF STATES WITH DISEASE SURVEILLANCE SYSTEMS, BY TYPE OF ENVIRONMENTALLY-INDUCED POISON

NOTE: THIS GRAPHIC CONTAINS MOCK DATA



* Total number of poisoning cases reported in the past year.

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FIGURE 42.
NUMBER OF CHILDREN SCREENED FOR LEAD POISONING, FOUND POSITIVE, AND RECEIVING APPROPRIATE FOLLOW-UP

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

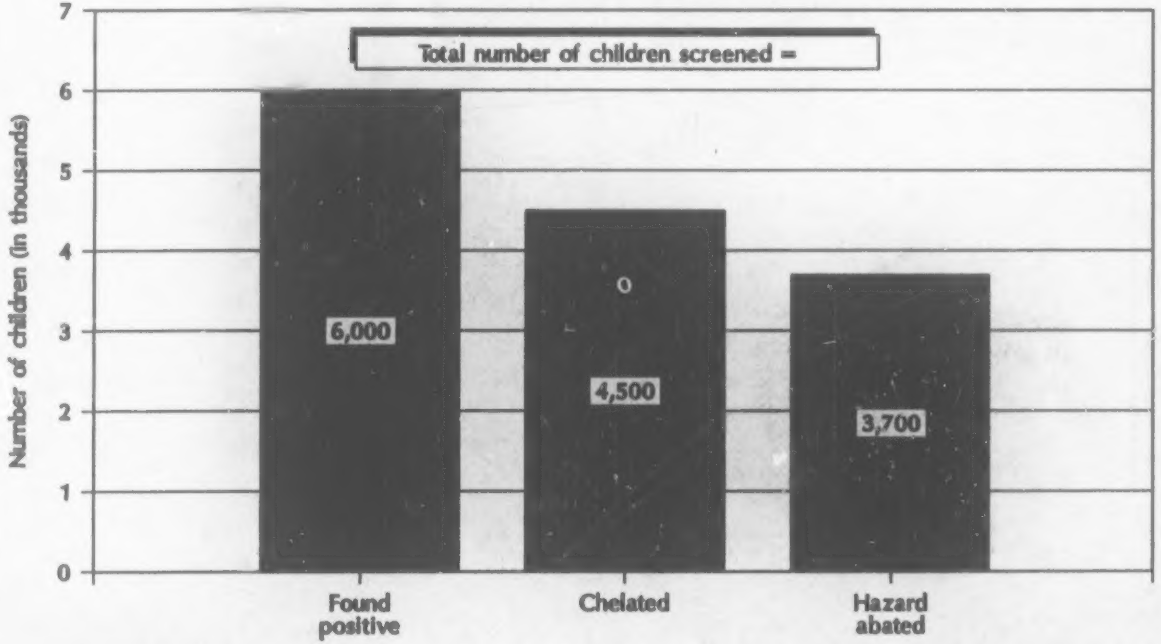

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FIGURE 43.
RADON TESTING AND ABATEMENT IN HIGH-RISK AREAS

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

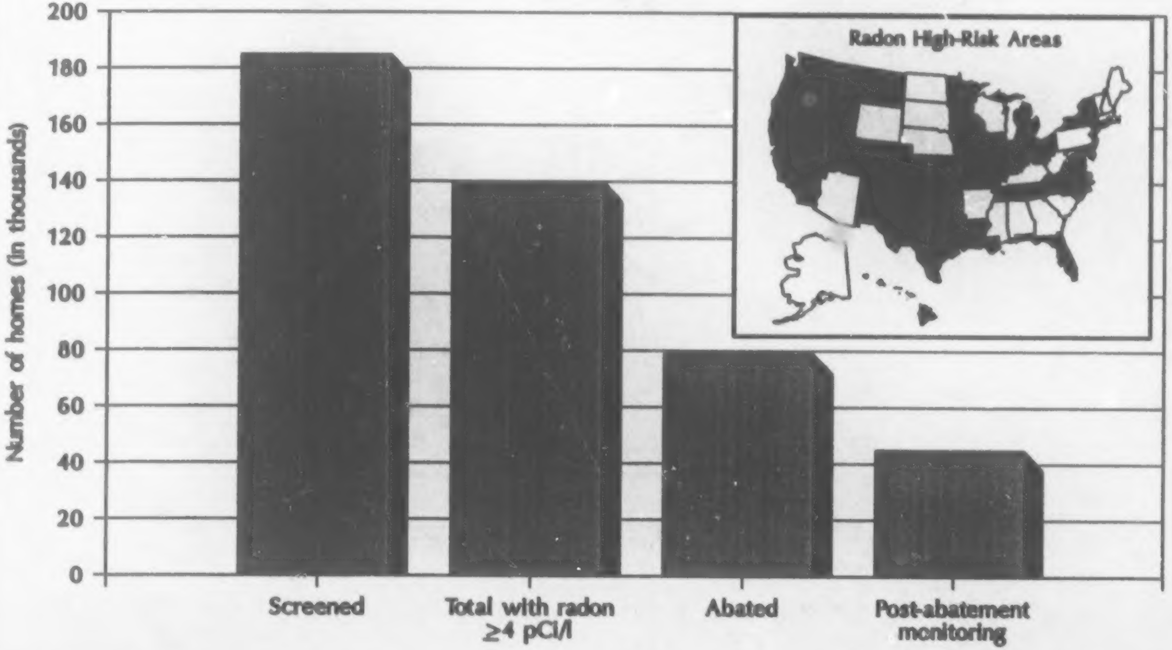

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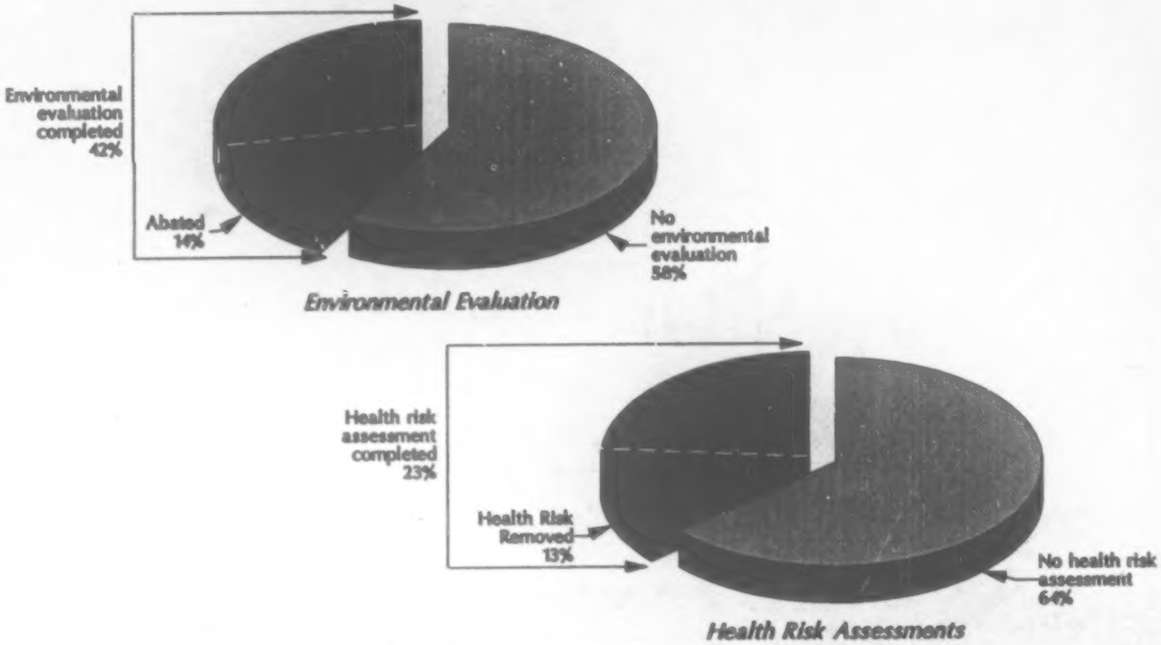
FIGURE 44.
IDENTIFIED HAZARDOUS WASTE SITES

NOTE: THIS GRAPHIC CONTAINS MOCK DATA



Environmental Evaluation

Health Risk Assessments

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FIGURE 45.
NUMBER OF STATES WITH INDOOR AIR LEGISLATION COVERING SMOKING, BY TYPE OF FACILITY

NOTE: THIS GRAPHIC CONTAINS MOCK DATA

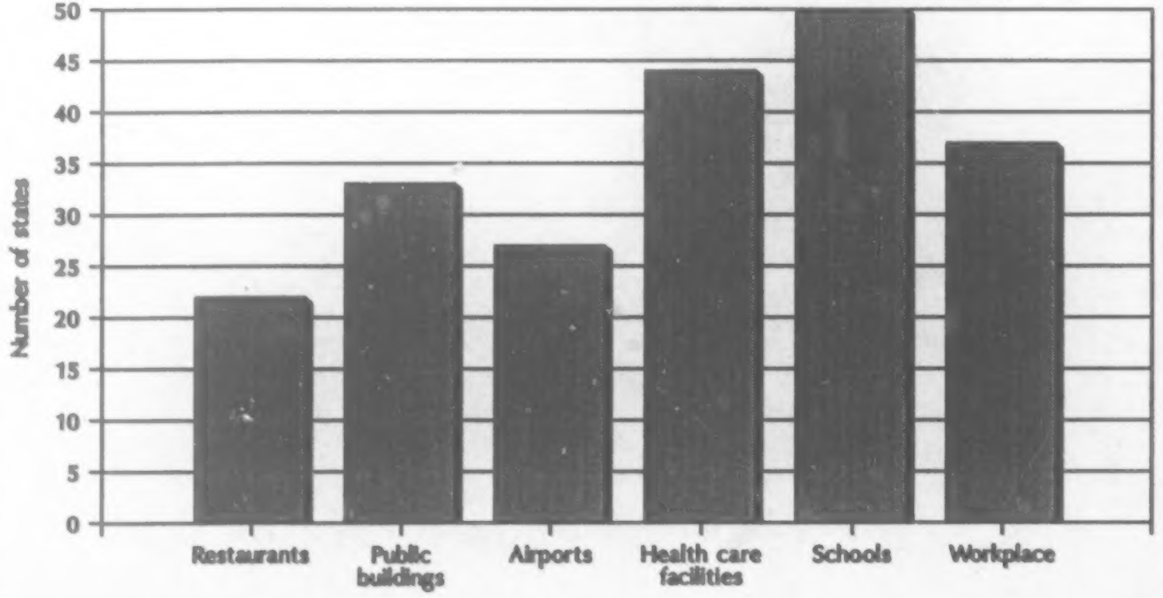

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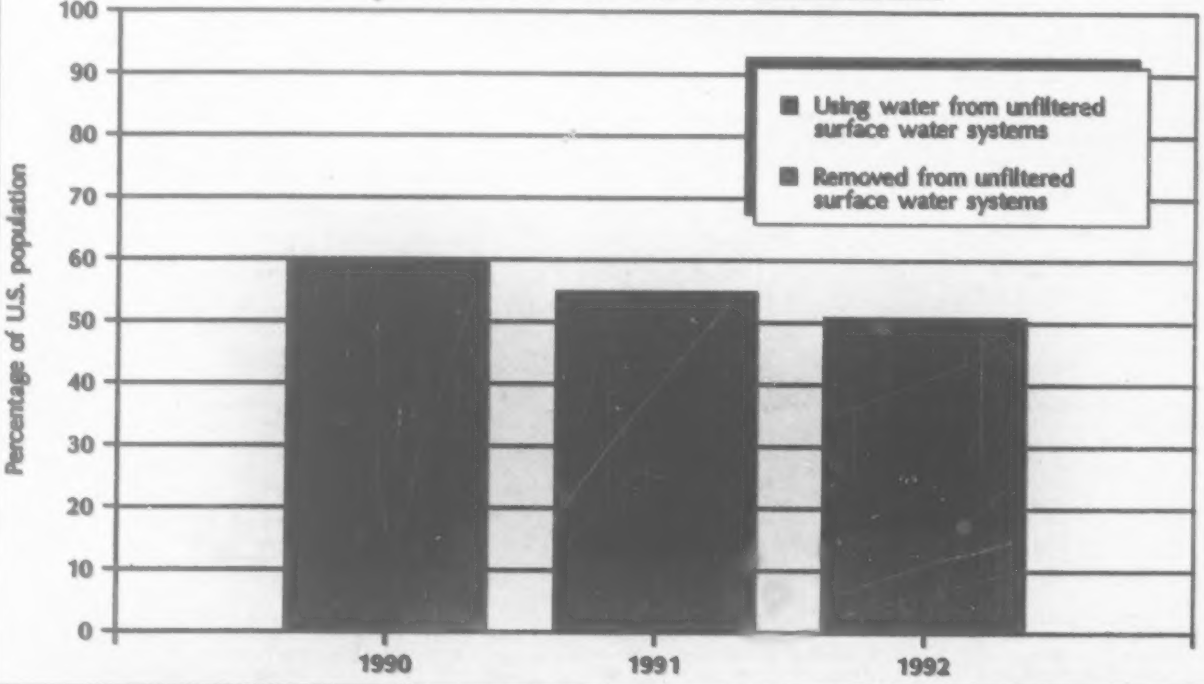
FIGURE 46.
PERCENTAGE OF U.S. POPULATION ON UNFILTERED SURFACE WATER SYSTEMS AND REMEDIATION, 1990-1992

NOTE: THIS GRAPHIC CONTAINS MOCK DATA



PUBLIC HEALTH FOUNDATION

April 1990

LIST OF PARTICIPANTS

Susan Addiss, M.P.H., M.Ur.S.
Director, Quinnipiack Valley
Health District
Chimney Square, 1141 Dixwell Avenue
Hamden, Connecticut 06514
(203) 776-8280

John R. Anderson
Deputy Associate Director
National Center for Health Statistics
3700 East-West Highway, Room 212
Hyattsville, Maryland 20782
(301) 436-7051

Delton Atkinson, M.S.P.H., M.P.H.
Director, Division of Statistics and
Information Services
Department of Environment, Health
and Natural Resources
P.O. Box 27687
Raleigh, North Carolina 27611-7687
(919) 733-4728

Doris M. Barnette, M.S.W., A.C.S.W.
Acting Director, Bureau of Family
Health Services
Alabama Department of Public Health
434 Monroe Street, Room 381
Montgomery, Alabama 36130
(205) 261-5052

Michael A. Barry
Senior Program Associate
Public Health Foundation
1220 L Street, N.W., Suite 350
Washington, D.C. 20005
(202) 898-5600

Richard M. Biery, M.D.
Director of Health
Kansas City Department of Health
414 East 12th Street, 10th Floor
Kansas City, Missouri 64106
(816) 274-1381

Guthrie S. Birkhead, M.D.
Physician - Epidemiologist
Bureau of Communicable Disease Control
New York State Department of Health
Corning Tower, Room 651
Albany, New York 12237
(518) 474-3187

John E. Brockert, M.P.H.
Director, Bureau of Health Statistics
State Department of Health
288 North 1460 West, P.O. Box 16700
Salt Lake City, Utah 84116
(801) 538-6186

Carolyn Caquelin
Chief, Bureau of Disease Assessment
Iowa Department of Public Health
Lucas State Office Building
Des Moines, Iowa 50319
(515) 242-5149

Alison Chacon
Program Associate
Public Health Foundation
1220 L Street, N.W., Suite 380
Washington, D.C. 20005
(202) 898-5600

Robert Chapman, M.D.
Health Effects Research Laboratory
U.S. Environmental Protection Agency
MD-51A
Research Triangle Park, North Carolina 27111
(919) 966-6219

William Christoffel
Office of Maternal and Child Health
Bureau of Maternal and Child Health and
Resources Development/HRSA
5600 Fishers Lane, Room 9-12
Rockville, Maryland 20857
(301) 443-3163

Rose Dieffenbach, M.P.H.
Program Associate
Public Health Foundation
1220 L Street, N.W., Suite 350
Washington, D.C. 20005
(202) 898-5600

James T. Dimas, M.P.A.
Executive Director
Public Health Foundation
1220 L Street, N.W., Suite 350
Washington, D.C. 20005
(202) 898-5600

Frances J. Dunston, M.D., M.P.H.
Director, Office of Family Health Services
Virginia Department of Health
James Madison Building, 6th Floor
109 Governor Street
Richmond, Virginia 23219
(804) 786-5214

Peter Edwards
Conference Planner
Public Health Foundation
1220 L Street, N.W., Suite 380
Washington, D.C. 20005
(202) 898-5600

Mary L. Ellis
Director of Public Health
Iowa Department of Public Health
Lucas State Office Building
Des Moines, Iowa 50319
(515) 281-5605

Sheldon B. Elman
Assistant Director of Administrative
Services
Utah Department of Health
P.O. Box 16700
Salt Lake City, Utah 84116-0700
(801) 538-6930

Henry Falk, M.D., M.P.H.
Director, Division of Environmental
Hazards & Health Effects/CEHIC
Centers for Disease Control
1600 Clifton Road, N.E.
Atlanta, Georgia 30333
(404) 488-4780

Edward A. Feaver
Deputy Director for Health
Department of Health and
Rehabilitative Services
Health Program Office
1323 Winewood Boulevard
Tallahassee, Florida 32399-3700
(904) 487-2705

Laurence R. Foster, M.D.
State Epidemiologist
Oregon State Health Division
P.O. Box 231
Portland, Oregon 97207
(503) 229-5821

Claude Earl Fox, M.D.
State Health Officer
State Department of Public Health
434 Monroe Street, Room 381
Montgomery, Alabama 36130-1701
(205) 261-5052

Thelma Fraziear, M.P.H., M.P.A.
Chief, Office of AIDS
California Department of
Health Services
P.O. Box 942732
Sacramento, California 94234-7320
(916) 445-0553

Holly Grason
Assistant Director
Association of Maternal and
Child Health Programs
2001 L Street, N.W., Suite 308
Washington, D.C. 20036
(202) 775-0436

Joel Greenspan, M.D., M.P.H.
Chief, Surveillance and Information
Systems Branch
Division of STD/HIV Prevention/CPS
Centers for Disease Control
1600 Clifton Road, N.E., MS E-02
Atlanta, Georgia 30333
(404) 639-2575

Paul D. Gunderson, Ph.D.
Director, Minnesota Center for
Health Statistics
Minnesota Department of Health
717 Delaware Street, S.E.
Minneapolis, Minnesota 55440
(612) 623-5358

Eileen Gunter, R.N., M.P.H.
Nurse Administrator
Division of Reproductive Health
Centers for Disease Control
1600 Clifton Road, N.E.
Building 1, Room 4054, C-06
Atlanta, Georgia 30333
(404) 639-3252

Gary C. Hogelin
Assistant Director for Policy
and Planning
Office of Surveillance and Analysis
Center for Chronic Disease Prevention
and Health Promotion
Centers for Disease Control, MS F-05
1600 Clifton Road, N.E.
Atlanta, Georgia 30333
(404) 639-2755

Sharon Keefer, M.S.
Health Statistics Section
Colorado Department of Health
4210 East 11th Avenue
Denver, Colorado 80220
(303) 331-4902

Edward Larkin, M.D.
Health Officer
Barry-Eaton District Health
Department
528 Beech Street
Charlotte, Michigan 48813
(517) 543-2430

B. LaDene Larsen, R.N.
Director, Bureau of Chronic Disease
Control
Utah Department of Health
P.O. Box 16660-0660
Salt Lake City, Utah 84116-0660
(801) 538-6141

Sheryl Lee, M.P.H., R.D.
Chief, Office of Nutrition Services
Arizona Department of Health Services
1740 West Adams, Room 208
Phoenix, Arizona 85007
(602) 542-1886

Art Liang, M.D.
Assistant Director for Epidemiology
Division of Public Health Systems
Public Health Practices Program Office
Centers for Disease Control
24 Executive Park, MS E-20
Atlanta, Georgia 30333
(404) 639-1960

David Lohrisch, Ph.D.
Chief, Bureau of Information
Resources
Mississippi Department of Health
P.O. Box 1700
Jackson, Mississippi 39215
(601) 987-3884

Sue Madden
Director, Health Services Information
Division
Public Health Foundation
1220 L Street, N.W., Suite 350
Washington, D.C. 20005
(202) 898-5600

Katherine Marconi, Ph.D.
Acting Chief, Cancer Control
Applications Branch
DCPC, NCI, EPN 233-E
9000 Rockville Pike
Rockville, Maryland 20892
(301) 496-8584

Richard Mitzelfelt
Director, Environmental Improvement Division
Harold Runnels Building
1190 St. Francis Drive Suite 4100
Santa Fe, New Mexico 87503
(505) 827-2850

William C. Myers, M.S.
Health Commissioner
Columbus Health Department
181 Washington Boulevard
Columbus, Ohio 43215
(614) 645-6228

R.M. Nicola, M.D., M.H.S.A.
Director
Seattle-King County Health Department
110 Prefontaine Place South, Suite 600
Seattle, Washington 98104
(206) 296-4603

Lloyd F. Novick, M.D.
Director, Center for Community Health
New York State Department of Health
Corning Tower, Room 695
Albany, New York 12237
(518) 474-5073

Lyman J. Olsen, M.D.
Director of Clinical Services
Community Health Branch
Division of Public Health
Jesse Cooper Building, P.O. Box 637
Dover, Delaware 19903
(302) 735-6603

Mary D. Peoples-Sheps, Dr.P.H.
Associate Professor
Curriculum in Public Health Nursing
300C Rosenau Hall, CB 7400
School of Public Health
University of North Carolina
at Chapel Hill
Chapel Hill, North Carolina 27599-7400
(919) 966-6878

Dennis M. Perrotta, Ph.D.
Director, Epidemiology Division
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756
(512) 458-7268

Walter Peter, M.D.
Chief, Bureau of Maternal and
Child Health
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756
(512) 458-7700

Molly E. Pickett
Acting Chief, Environmental Health
Public Health Foundation
1220 L Street, N.W., Suite 350
Washington, D.C. 20005
(202) 898-5600

James F. Quilty, Jr., M.D.
Chief, Division of Maternal and
Child Health
Ohio Department of Health
246 N. High Street, P.O. Box 118
Columbus, Ohio 43266
(614) 466-3263

N. Mark Richards, M.D.
Secretary of Health
Department of Health
P.O. Box 90
Health and Welfare Building, Room 802
Harrisburg, Pennsylvania 17108
(717) 787-6436

H. Hugh Rohrer, M.D.
Director
Tri-County Health Department
7000 E. Belleview, Suite 301
Englewood, Colorado 80111
(303) 220-9200

Charles Rothwell
Associate Director
Office of Data Processing and Services
National Center for Health Statistics
3700 East-West Highway, Room 1-20
Hyattsville, Maryland 20782
(301) 436-7135

Daniel Sadler
Project Officer, Pregnancy and Infant Health Branch
Division of Reproductive Health
Center for Chronic Disease Prevention and
Health Promotion
Centers for Disease Control
1600 Clifton Road, N.E., MS C-06
Atlanta, Georgia 30333
(404) 639-3131

Stephen Saunders, M.D., M.P.H.
Chief, Division of Family Health
Illinois Department of Public Health
535 West Jefferson Street
Springfield, Illinois 62761
(217) 782-2736

Thomas L. Schmid, Ph.D.
Visiting Scientist
Cardiovascular Health Branch
MS A-13
Centers for Disease Control
1600 Clifton Road, N.E.
Atlanta, Georgia 30333
(404) 639-3818

Paul R. Silverman, Dr.P.H.
State Epidemiologist
Division of Public Health
Jesse Cooper Building
P.O. Box 637
Dover, Delaware 19903
(302) 736-5617

E. Jerry Spyke
Office of Surveillance and Analysis
Center for Chronic Disease Prevention
and Health Promotion
Centers for Disease Control
1600 Clifton Road, N.E., MS F-05
Atlanta, Georgia 30333
(404) 639-3146

John T. Tierney
Deputy Director of Health
Rhode Island Department of Health
3 Capitol Hill
Providence, Rhode Island 02908
(401) 277-2231

Kathy Ward
Director, Division of Chronic Disease
and Disabilities
Nebraska State Department of Health
301 Centennial Mall South
P.O. Box 95007
Lincoln, Nebraska 68509-5007
(402) 471-3914

Frances C. Wheeler, Ph.D.
Director, Center for Health Promotion
South Carolina Department of Health
and Environmental Control
2600 Bull Street
Columbia, South Carolina 29201
(803) 737-4120

Rebecca Zagraniski, Ph.D.
Assistant Commissioner, Occupational
and Environmental Health
New Jersey State Department of Health
John Fitch Plaza, CN 360
Trenton, New Jersey 08625-0360
(609) 292-5617

The Feasibility of Behavioral Risk Reduction in Primary Medical Care

Donald N. Logsdon, MD, Carolyn M. Lazaro, MA,
and Roger V. Meier, BS

This prospective study evaluated changes in patients' health-risk behavior one year after preventive intervention by primary care physicians. The trial used a quasiexperimental design with 2,218 adults (1,409 study subjects and 809 controls) at five multispecialty, group practice sites in three regions of the United States. Pre- and postintervention surveys showed that the treated study patients with behavioral risks were more likely to report positive changes than were controls in regard to beginning regular exercise ($P = .02$), using auto seat belts, ($P < .001$), losing weight ($P = .05$), decreasing alcohol intake ($P = .01$), and to performance of monthly breast self-examination by women ($P < .001$). The smoking cessation rate was greater among the treated study group compared with the controls, although the change was not significantly different. Greater behavioral risk changes also occurred among the total study group (treated and untreated) in comparison with the control group. An additive index of these behavioral risks showed greater reduction among the treated and the total group of study patients compared with controls. These initial results suggest that clinical preventive services, which include risk factor education and counseling by primary care physicians, can improve short-term health-related behavior of patients. [Am J Prev Med 1989;5:249–56]

This study is part of the INSURE (Industrywide Network for Social, Urban and Rural Efforts, a nonprofit corporation) Project, which began in 1980 to determine the feasibility of preventive medical services in primary care.[1] In 1984 the study was extended to evaluate the long-term effects of the services on patients' health-risk behavior, physicians' practice patterns, and costs.

National interest in prevention has been heightened by changing patterns of morbidity and mortality in the last several decades. Other than the current AIDS outbreak, which must be taken into account, infectious diseases are no longer the major killers. In 1984 the age-adjusted leading causes of death were heart disease (33.6%), cancer (24.5%), accidents (6.4%), and stroke (6.1%).[2] Epidemiologic research on lung cancer[3] and coronary heart disease risk factors[4] combined with the clinical trials of breat cancer screening[5] and the treatment of hypertension[6] have stimulated interest in preventive medical services for adults.

Evaluation reports with guidelines regarding clinical preventive services were developed in Canada and the United States[7,8] and summarized to assist physicians in developing individualized preventive plans for asymptomatic patients.[9] A developmental approach to clinical preventive measures was proposed by Breslow and Somers[10] in 1977. However, the training and practice of physicians have been oriented toward treatment of sick patients, and the existing reimbursement mechanisms and time demands on physicians have led to a general skepticism about the practice of preventive medical services.[11] Despite the aforementioned guidelines, many physicians lack the requisite information and techniques for the office practice of prevention[12] and doubt the effectiveness of certain preventive services.[13]

In 1980 the average American made 4.8 primary medical care visits, and 75% made at least one physician visit a year (including telephone consultation and excluding in-hospital visits).[14] There is a tremendous opportunity to provide preventive services in day-to-day practice using a medical model.[15] Because of primary care physicians' unique relationship with individual patients, these physicians are in an unparalleled position to reduce health risks.

The INSURE Project, therefore, addressed the

From the Department of Community Medicine, Mt. Sinai School of Medicine, City University of New York (Logsdon), and the INSURE Project (Logsdon, Lazaro, and Meier), New York, New York.

Address reprint requests to Stanley G. Karson, The INSURE Project, 1001 Pennsylvania Ave, NW, Washington, DC 20004.

following questions: will primary care physicians use a model based on current guidelines to provide preventive services; will patients reduce their behavioral risks; and how much will the preventive services cost? This report focuses on the initial behavioral risk changes among nonpregnant adult patients receiving primary medical care at fee-for-service, multispecialty group practices.

METHODS

Intervention

We used a quasiexperimental design[16] to evaluate behavioral risk changes over time in randomly selected study and control patients at study and reference group practice sites. Multispeciality group practices were selected for the trial because the primary care physicians were available as a unit (i.e., family practitioners, internists, obstetricians–gynecologists, and pediatricians). From a list of 28 multispecialty group practices provided by the American Group Practice Association, the project approached six clinics as study sites, and three agreed to participate. After agreement with each study site, efforts were made to locate a comparison reference site of corresponding physician composition, practice characteristics, community size, and state or geographic region. Of the five group practice reference sites approached, two agreed to participate. The main reason group practices gave for refusal was the inability to adhere to the cycle of surveys or patient visits required by the study. The five participating group practices (three study sites and two reference sites) varied from 14 to 21 primary care physicians per group practice center.

At the study sites, the physician participation rates were: Appleton, Wisconsin, 100% (17); Danville, Pennsylvania, 81% (17); and Pensacola, Florida, 86% (12). At the reference sites the physician participation rates were: Sheboygan, Wisconsin, 74% (14); Sayre, Pennsylvania, 86% (12). Practitioners gave different reasons for not participating, such as developing subspecialty practices, teaching responsibilities, and heavy patient schedules. Physicians received honoraria for participation in telephone surveys and training programs conducted by the INSURE Project. The professional characteristics, baseline attitudes toward, and practice of preventive services by these primary care physicians at the study and reference sites have been previously reported.[17]

A model of preventive medical services was developed from guidelines in the medical literature and consensus standards of committees expert in pediatrics, obstetrics–gynecology, family practice, and internal medicine.[9,18–20] These reports and recommendations were merged into protocols for nine age groups, from infancy through old age, and included pregnant women.

The protocols contained age- and sex-specific medical screening procedures and patient education and counseling techniques for behavioral risk reduction. The intervention at the study sites involved the physicians' use of prevention-oriented encounter forms for recording the patients' risk history and providing the physical examination, clinical laboratory tests, radiologic studies, and immunizations that were indicated according to the clinical findings and the protocols for well patients.

The targeted risks for adults included high blood pressure, smoking, lack of exercise, excessive dietary fat, overweight, alcohol misuse, irregular breast self-examination, and nonuse of auto seat belts. The encounter forms included a prevention prescription for recording the study site physicians' counseling on how to reduce each patient's risks. Copies of the encounter forms were used by the project staff for clinical data collection and monitoring of protocol adherence by the study site physicians. Informational guides and educational materials for the patients at the study sites were used to focus attention on preventive self-care after the patient visits.

Continuing medical education (CME) seminars were held with the physicians at the three study sites to review the protocols, discuss problem cases, and present feedback on study patients. INSURE assumed financial responsibility for the patients' preventive medical services at the study sites according to negotiated payment schedules. At least 15 minutes for patient education and counseling on risk reduction by the physicians was specifically allocated in the study protocols and the payment schedules. There were no INSURE Project educational seminars held at the two reference group practice sites. The control patients at the reference sites received usual medical care at their expense.

Data Collection

The sampling frames for study and control patients were the computerized billing rosters of participating primary care physicians at the five sites. Eligible patients included those who had made one or more visits to the participating physicians in the previous two years. Patients with serious chronic diseases were considered ineligible if their diagnoses were coded as cancer, heart disease, or juvenile diabetes.[21]

The lists of patients were first stratified by age and sex, and the eligible patients were randomly drawn within the strata. The Sheboygan, Wisconsin, reference site did not have this capacity, so the sample was drawn from a printout of patient visits. At the Pensacola, Florida, study site, release statements were required from the randomly drawn sample of patients, and this group constituted the eligible sample for the study. This patient release procedure made it impossible to obtain a third reference site within the time frame of the feasibility study.

The study design specified a minimum of 75 patients in each age group. The baseline surveys at time 1 (T1) were by mail only; the follow-up surveys (T2) 12 months later were by mail with comprehensive telephone follow-up, to achieve a greater than 80% response rate in each age group. Because of the emphasis on reducing cardiovascular disease risks, an extra sample of 200 men 40 to 59 years of age was also drawn at each study site.

Identical survey procedures were used at all five sites. Each study site and then its reference site were surveyed beginning in 1982 and ending in 1983. The patient surveys measured patients' health habits and behavioral risks, sociodemographic characteristics, perceived health status, and psychosocial variables. An abbreviated telephone questionnaire was used in an intensive follow-up of a subsample of nonrespondents to help assess possible response biases.

After completing the T1 survey questionnaires, the study patients requested and obtained appointments with their primary care physicians for preventive visits without charge. The follow-up (T2) surveys at the study and reference sites were done 10–12 months after the preventive patient visits at the study sites. All T1 respondents were resurveyed at T2 regardless of whether or not they had preventive visits with their physicians.

Data Analysis Plan

Because pregnant women have very different patterns of preventive health care, they were excluded from our analyses. Possible selection bias on the part of the study and control groups was investigated by comparing the T2 respondents and nonrespondents with respect to sociodemographic characteristics and behavioral risk prevalence on the T1 survey. Within the study group, similar comparisons were also made of participants (treated) and nonparticipants (untreated) in the preventive intervention (examination and counseling). Because there was oversampling of middle-aged men in the study group, stratification and log-linear analyses were used to control for age and sex variations.

A logistic regression model[22] was used to evaluate the risk changes from the T1 to T2 survey among the study and control patients who had reported risk behavior on the T1 survey. For each behavioral risk, the sociodemographic characteristics that differed between the study and control patients at risk were allowed to enter the model as covariates using the step-up/step-down procedure in the BMDP statistical software package if they met the conservative criterion of $P < .15$.[23] The group status (study or control) variable was then entered in the logistic model, and the P value for its inclusion was calculated by the difference in log likelihood. The odds ratio for group status and its 95% confidence interval were calculated from the logistic regression coefficient and its standard error.

RESULTS

Response Rates

At the three study sites, a total of 2,317 nonpregnant adult study patients of the participating primary care physicians were randomly sampled; at the two reference sites, 1,992 control patients were randomly sampled. The response rates to the T1 mail questionnaire was 61% for the study group and 41% for the control group. The difference probably was due to the availability of a preventive examination without charge to the study patients.

A comparison of the T1 respondents and the 5% sample of the nonrespondents from the study group showed no significant differences in sociodemographic characteristics and prevalence of behavioral risks. Among the control patients, a comparison of the T1 respondents with a 4% sample of nonrespondents showed that the nonrespondents were more often men, but they were comparable on other sociodemographic characteristics and on behavioral risk prevalence. Among the nonpregnant adult respondents at the study sites, 811 (58%) received INSURE preventive visits (treated study group), and 598 (42%) received usual medical care (nontreated study group).

Description of Patients

The sociodemographic characteristics and behavioral risk prevalence of patients at the third study site (Pensacola, Florida) were comparable with those of the other two study sites and were, therefore, incorporated into the analyses, even though a paired control site was not obtained. The data on

Table 1. Time 1 baseline sociodemographic characteristics of study and control patients

	Study			
	Total (*n* = 1,409), %	Treated (*n* = 811), %	Untreated (*n* = 598), %	Control (*n* = 809), %
Sex				
Male	54.7	57.7	50.7	39.6
Female	45.3	42.3	49.3	60.4
Age (years)				
18–24	15.0	10.9	20.6	17.1
25–39	18.8	19.5	17.9	18.2
40–59	37.1	39.0	34.6	20.9
60–74	18.7	21.2	15.2	26.9
≥75	10.4	9.5	11.7	16.9
Education				
< High school	18.1	17.2	19.3	23.4
High school graduate	35.4	34.5	36.7	36.2
Some college	26.8	28.4	24.6	25.4
College graduate	19.7	19.9	19.4	15.0
Religion				
Protestant	63.2	62.9	63.7	64.4
Catholic	30.5	31.1	29.6	24.7
Other	6.3	6.1	6.7	10.9
Marital status				
Married	68.1	70.8	64.4	62.6
Employment				
Employed	61.2	61.7	60.2	43.9
Unemployed	10.5	8.9	12.8	10.9
Retired	18.8	19.9	17.2	28.8
Housekeeper	9.6	9.5	9.8	16.3
Income				
<$10,000	21.4	19.1	24.6	28.7
$10,000–19,999	28.6	29.2	27.7	32.8
$20,000–29,999	22.4	23.7	20.6	20.3
≥$30,000	27.5	27.9	27.0	18.1
Race				
White	97.2	97.2	97.2	98.0

Table 2. Time 1 baseline behavioral risk prevalence of study and control patients

	Study			
	Total (*n* = 1,409), %	Treated (*n* = 811), %	Untreated (*n* = 598), %	Control (*n* = 809), %
Smoke cigarettes	20.8	19.4	22.8	21.3
Do not engage in regular exercise[a]	55.4	55.7	54.9	55.3
Do not always use seat belts	85.2	84.6	86.1	81.6
Overweight[b]	23.3	24.6	21.6	21.9
Heavy drinker (≥14 drinks per week)	12.8	13.5	11.7	8.0
Women only				
Never or infrequent BSE[c] (less than monthly)	63.8 (*n* = 638)	68.3 (*n* = 343)	58.5 (*n* = 295)	70.8 (*n* = 489)

[a] Vigorous physical exercise once a week or more.

[b] Overweight calculated from reported height and weight with body mass index = wt (kg)/ht (m)^2 ≥27.8 for men and ≥27.3 for women.

[c] BSE = breast self-examination.

baseline sociodemographics and behavioral risk prevalence of the study and control groups (Tables 1 and 2) were reviewed for evidence of differences. Comparison of the total study group with the control group showed differences in sex and age group, reflecting the oversampling of middle-aged males at the study sites. After these differences in sex and age groups were controlled with log-linear analysis, the total study and control groups showed small differences in religion and employment but were similar in education, marital status, income, and race. Patient-reported behavioral risk prevalence at T1 was equivalent between the total study and control groups (Table 2), except that the prevalence of women who never practiced BSE was higher in the control group.

Within the total study group, patients who participated in the preventive intervention (treated group) were more frequently men and middle-aged than study patients who did not participate (untreated group); after these differences were controlled for, the treated and untreated study patients were comparable regarding all other sociodemographic characteristics. Treated and untreated study patients reported a similar prevalence of behavioral risks at baseline, except for infrequent BSE, which was more prevalent among women who participated in the preventive intervention. Additional analyses suggest that the treated study patients were more likely to have had fewer and less recent visits to a physician in the past year and were less likely to have had a check-up in the past year in comparison to the untreated study patients.

To summarize the overall pattern of prevalence and change among the patients for the six behavioral risks, we constructed an index by adding the number of reported risk behaviors and dividing by the total number of potential risk behaviors for each patient. This behavioral risk index included four of five health risk behaviors that comprised the health practice index by Berkman and Breslow[24]: cigarette smoking, alcohol consumption, physical activity, and weight status in addition to seat-belt use and, for women, BSE. Each individual risk does not contribute equally to risk of morbidity or mortality, but for purposes of analysis, each behavior risk was weighted equally. At the baseline T1 survey, the study patients, both treated and untreated, and the control patients were virtually identical and all reported themselves as engaging in less than half (0.41–0.42) of the behavioral risks.

Eighty percent of all baseline T1 respondents were followed at the T2 survey in both the study and the control groups. Based on T1 survey data, the T2 nonrespondents from both groups tended to be of lower educational level and to have lower incomes than the respondents, and they showed a higher prevalence of cigarette smoking. There were no differences in self-selection between the study and control groups in the response to T2 surveys.

Behavioral Risk Change

For each risk behavior, patients who reported risks at the T1 survey were included in the analysis of behavioral risk change if the T2 survey was completed. The multiple logistic regression analyses were performed in two ways: by comparing the treated study group that had the preventive intervention with the control group and by comparing the total study group (treated and untreated) with the control group. Tables 3 and 4 show the percentages of patients with behavioral risk change at T2, the controlled sociodemographic variables, the adjusted odds ratios and corresponding 95% confidence intervals, and the two-tailed *P* values. The odds ratio gives an indication of change likelihood among study patients in comparison to control patients.

After controlling for sociodemographic confounders, the treated study group with behavioral risks more frequently reported positive changes at T2 than the controls in five of the six risk behaviors (Table 3). Although the cessation rate among cigarette smokers in the treated study group was greater than in the control group, the difference was not significant. Significant change differences occurred between treated study and control patients with regard to: starting regular physical exercise ($P = .02$), beginning to always use auto seat belts ($P < .001$), losing five pounds or more among overweight patients ($P = .05$), reducing alcoholic beverage intake among heavier drinkers ($P = .01$), and women performing monthly BSE ($P < .001$). The change rates among the untreated study group are included in Table 3 for informational purposes. For four of six behaviors, the untreated study group had change rates similar in magnitude to that of the control group. However, weight reduction was more comparable to that of the treated study group, and decreased alcohol drinking was highest among the untreated study group. The change rates noted among the untreated study group suggest that other factors may have influenced the behavior change of study group patients with weight loss and decreased drinking, and the intervention effects for these two behaviors should be interpreted with caution.

Because various biases may have been operating in the self-selection of study patients for the preventive intervention, a comparison of the total study group (treated and untreated study patients)

Table 3. Behavioral change among adults at risk in treated study group only and control group

	Treated study group		Control group		Controlled variables[a]	Adjusted odds ratio (95% confidence intervals)	Untreated study group	
	%	*n*	%	*n*			%	*n*
Quit smoking	16.2	22	11.5	15		1.49 (0.74–3.02)	11.4	10
Started exercising	33.8	140	24.1	83	1,2,9	1.65* (1.12–2.43)	27.3	63
Began always using seat belts	22.8	138	8.0	40	4,5	3.59** (2.45–5.27)	10.1	37
Lost ≥5 lb	37.6	67	24.8	36	2	1.65* (1.00–2.72)	34.4	31
Reduced heavy drinking	32.6	31	21.4	9	2,5	3.30* (1.23–8.84)	45.7	21
Women only								
Began monthly BSE[b]	50.7	106	18.8	52	1	4.63** (3.04–7.05)	25.0	29

[a] Nine sociodemographic variables were allowed to enter the stepwise logistic regression procedure and were controlled for if they contributed to the model at $P < .15$. Their corresponding numbers are: (1) age group, (2) sex, (3) education, (4) employment status, (5) marital status, (6) race, (7) religion, (8) income, and (9) state by group status interaction.
Categories for covariates are as shown in Table 1.

[b] BSE = breast self-examination.

*$P < .05$.

**$P < .001$.

P values calculated by differences in log likelihood after group status (study versus control) was entered into logistic model.

with the control group was performed (Table 4). When the total study group (treated and untreated) was compared with the control group, the change differences between the two groups were maintained with regard to: beginning to always use auto seat belts ($P < .001$), losing five pounds or more among overweight patients ($P = .04$), reducing alcoholic beverage intake among heavier drinkers ($P = .01$), and, for women, performing monthly BSE ($P < .001$). The difference between the groups in starting regular physical exercise became marginally significant ($P = .06$).

Table 4. Behavioral change among adults at risk in total study group and control group

	Total study group		Control group		Controlled variables[a]	Adjusted odds ratio (95% confidence intervals)
	%	*n*	%	*n*		
Quit smoking	14.3	32	11.5	15	7	1.47 (0.75–2.87)
Started exercising	31.5	203	24.1	83	1,2,9	1.39* (0.99–1.96)
Began always using seat belts	18.0	175	8.0	40	2,4	2.71**** (1.87–3.93)
Lost ≥5 lb	36.6	98	24.8	36	2	1.61** (1.02–2.56)
Reduced heavy drinking	36.9	52	21.4	9	2,5	3.45*** (1.40–8.47)
Women only						
Began monthly BSE[b]	41.5	135	18.8	52	1,3	3.49**** (2.35–5.18)

[a] Nine sociodemographic variables were allowed to enter the stepwise logistic regression procedure and were controlled for if they contributed to the model at $P < .15$. Their corresponding numbers are: (1) age group, (2) sex, (3) education, (4) employment status, (5) marital status, (6) race, (7) religion, (8) income, and (9) state by group status interaction.
Categories for covariates are as shown in Table 1.

[b] BSE = breast self-examination.

*$P < .10$.

**$P < .05$.

***$P < .01$.

****$P < .001$.

P values calculated by differences in log likelihood after group status (study versus control) was entered into logistic model.

Because the study design was, in principle, the sampling of paired study and control sites from several states, we evaluated the degree of consistency of the odds ratios for behavioral change across these study–control pairs. In effect, this assesses whether there was a greater effectiveness of the preventive intervention at some study sites than at others (or it also could reflect the vagaries of other unknown variables that might cause site-to-site differences). This was analyzed by stepping into the logistic regression model an interaction term for state by group status after the group status variable had already been included. For only one dependent variable (physical exercise) was there even an indication of interaction at the $P < .15$ level. When the odds ratios for physical exercise were examined for the individual states, they were qualitatively similar—all in the positive direction—but varied somewhat in magnitude. In summary, the study and control pairs were largely homogeneous in showing intervention effects, and, in the case of heterogeneity, there was still a consistency in the direction of the effect.

The behavioral risk indexes for T1 and T2 were calculated for the patients with both surveys. The index means of the groups are shown in Figure 1. After controlling for the baseline risk index through analysis of covariance, the treated study group had reduced its behavioral risk index at T2 significantly more than the control group: $F(1,1390) = 89.17$, $P < .001$. A significantly reduced risk index at T2 also was noted for the total study group (both treated and untreated) in comparison with the control group: $F(1,1829) = 51.47$, $P < .001$.

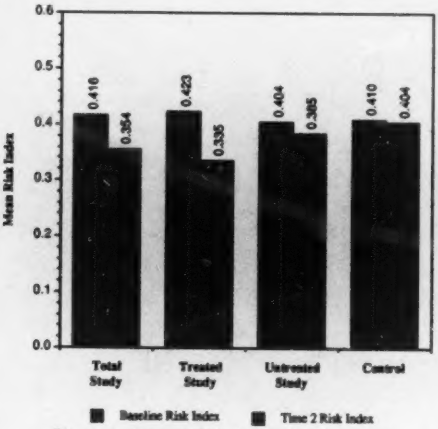


Figure 1. T1 and T2 behavioral risk indexes.

DISCUSSION

The effects of preventive medical services involving behavioral risk education and counseling were demonstrated over a 12-month period in this feasibility study. Primary care physicians at group practice study sites brought about greater improvements in self-reported, health-related behavior among their adult study patients than the changes reported by control patients at reference sites.

These short-term results indicate the potential benefits of a medical model for reducing five important behavioral risks associated with morbidity and mortality among adults: lack of regular exercise, nonuse of auto seat belts, overweight, misuse of alcohol, and irregular or no BSE among women. A trend toward increased smoking cessation among the intervention group was noted. The effects of the intervention were particularly evident in an index comparing the reduction in behavioral risks between treated study and control patients. Determination of the longitudinal changes of these behavioral risks will be required to evaluate the health benefits of the preventive intervention.

The magnitude of the self-reported change in behavioral risks among the control patients at the reference sites was also noteworthy. Whether these changes by the control patients were the result of self-selection, usual medical care, the survey process, or secular trends cannot be determined from this study. The use of a quasiexperimental design in a natural medical setting along with multiple logistic regression analysis to obtain covariates-adjusted change would be appropriate for this comparative clinical trial.

Implementation of the protocols for preventive medical services in this study included a CME module with training for physicians in patient communication skills and the epidemiologic evidence for disease prevention. Previous studies of preventive interventions focused on single diseases and associated risk factors, most notably the prevention of coronary heart disease.[25] Except for smoking cessation, these studies did not include the counseling of patients at risk by primary care physicians regarding other important causes of adult morbidity and mortality.

This study showed that the initial costs for the medical model of preventive services in primary care are controllable and that patient utilization patterns are definable.[26] Thus, the implementation of preventive medical services appears feasible if medical training is provided and financial barriers for patients and physicians are removed. Innovation on the part of third-party payers and medical educators will be necessary to transfer the results of this feasibility study to medical care in general.

The economic impact of work site preventive services has been demonstrated on a longitudinal basis.[27] Cost analysis is also required of preventive medical services in primary care as an alternative approach that includes employees as well as dependents and all age groups. Despite the complexities in design, analysis, and duration of such efforts, all of which add to the expense, the cost-effectiveness of prevention in primary care warrants further study. The initial results of the INSURE Project indicate that better health through preventive medical services can result from this kind of investment, but the INSURE Project makes no claim that prevention can control the rising cost of medical care.

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Hepatitis B: The Silent Epidemic

While the United States and the world turn their attention to the tragedy of AIDS, another virus—just as deadly and far more prevalent—goes almost unnoticed, a time bomb waiting to explode.

"Hepatitis B is the most important chronic viremia in the world bar none, including AIDS," according to Sanford F. Kuvin, MD, vice-chairperson of the board of trustees, National Foundation for Infectious Diseases, Bethesda, MD. Speaking at the Fourth National Forum on AIDS and Hepatitis B in Washington, DC, last November, Kuvin underscored the real tragedy of the hepatitis B epidemic: The disease is almost entirely preventable.

Hepatitis B represents the first time in the history of the United States that an effective vaccine has been introduced with no significant decrease in the incidence of infection, Kuvin said. In fact, the incidence of hepatitis B has actually risen since 1982, when the vaccine was first distributed, according to evidence reported in the November 2 issue of the *New England Journal of Medicine*.

Kuvin said that this "incubating national tragedy" has been caused by a combination of apathy, ignorance, and lack of public and professional education. Although several members of the audience disagreed with him, Kuvin insisted that "cost is not the main event" in preventing use of the vaccine. The cost will certainly decrease as more organizations make use of the vaccine, but the other factors mentioned pose more important obstacles, he said.

Kuvin said this "incubating national tragedy" was caused by apathy, ignorance, and a lack of education.

The Incidence

Kuvin noted that 300,000 new infections with hepatitis B virus (HBV) occurred in the United States in 1988, with an estimated 1.8 million chronic carriers. As bad as this may be, the United States is just "playing catch-up" with the rest of the world, Kuvin said. In some areas such as Southeast Asia, tropical Africa, and the Amazon basin, the lifetime risk of infection is 70 percent to 90 percent. There are almost 300 million chronic carriers globally; of those, Kuvin noted, about 60 million will die from the sequelae of hepatitis B, and 1.8 million children born in 1988 will die of it.

Hepatitis B is a particular problem among healthcare workers, who acquire the infection through exposure to contaminated blood. The Centers for Disease Control (CDC), Atlanta, has estimated that each year more than 1,200 healthcare workers become infected with HBV, according to James O. Mason, MD, DPH, assistant secretary of health, Department of Health and Human Services, Washington, DC. Mason told conference participants that 500 to 600 of these workers are hospitalized as a result of the infection. Some 700 to 1,200 of these infected people will become carriers, and about 250 will die of cirrhosis or cancer of the liver caused by the virus.

Mason also said that studies indicated that 10 percent to 30 percent of all healthcare or dental workers show serological evidence of past or present infection with HBV; this figure contrasts with reports in the literature of only 26 healthcare workers with occupationally acquired HIV (human immunodeficiency, or AIDS, virus) infections.

One factor accounting for the marked difference in infection rates is that HBV is far more contagious than HIV. According to Kuvin, if a person is pricked accidentally with an HIV-contaminated needle, the chances of infection are less than 0.5 of 1 percent; if pricked with HBV, the chances are 40 percent. The two diseases are transmitted by the same methods, however: sex, blood, needles, and birth.

The costs related to hepatitis B are enormous: approximately $600 million to $700 million per year for direct medical costs, not including indirect costs and time lost from work, according to Harold S. Margolis, MD, chief of the Hepatitis Branch of the CDC. And the death toll is high as well, since hepatitis B is a primary cause of chronic liver disease, the eighth leading cause of death in the United States, accounting for 25,000 deaths each year.

FIRST STEPS

The way to control the disease, Kuvin said, is through universal vaccination (see **Box,** below). The National Foundation for Infectious Diseases estimates that about 30 million Americans need vaccination today, and it is calling for eventual vaccination of all infants, children, adolescents, and targeted high-risk groups, which include sexually active heterosexuals (the most rapidly expanding group, accounting for 22 percent of new infections), intravenous drug abusers (26 percent of new infections), and homosexuals (5 percent of new cases).

A first step toward achieving this goal is being taken by the U.S. Occupational Safety and Health Administration (OSHA), which is revising guidelines requiring employers to offer vaccinations to employees who are exposed to blood one or more times per month. Although the regulations will apply to all employers, the healthcare industry will be most affected: 4.7 million of the 5.3 million workers affected are in healthcare facilities, according to Gerard F. Scannell, assistant secretary of labor at OSHA. He estimated that implementation of the standard will prevent 10,000 HBV infections and 200 deaths each year.

Hepatitis B is a particular problem among healthcare workers, according to Mason.

The vaccination requirements are part of a package of proposed standards to protect workers from AIDS and hepatitis B. Based on CDC recommendations regarding universal precautions, the proposal also addresses engineering controls, work practices, and training.

The proposal was made public in late May 1989, and OSHA is still receiving comments and briefs from the public, which it will consider before releasing the final regulations. Some experts estimate that could be more than a year away. (For more information, see Mark A. Kadzielski, "OSHA Proposals Create Cost and Compliance Problems," *Health Progress*, December 1989, p. 75.)

The proposed regulations have generated much controversy and comment. Scannell said that OSHA has received more than 1,500 written comments, an OSHA record. One point of contention is the requirement that only workers exposed to blood once or more per month be offered the vaccination. Mason noted that the Public Health Service recommends, instead, that the vaccine be offered to all persons involved in work to which universal precautions apply. In addition, Mason noted, medical and dental students and other trainees should be offered the vaccine "in sufficient time to begin the series before the first blood exposures occur. They should not be required to first establish a work history of exposure."

ATTACKING THE EPIDEMIC

The first step to curbing the hepatitis B epidemic is for healthcare professionals to educate themselves, their colleagues, and the public about this "incubating national tragedy," according to Kuvin. The formation of significant coalitions is necessary to implement vaccination programs in target groups, and some success has already occurred in this area. For example, prenatal screening for HBV has risen to 60 percent, Kuvin said.

To systematize the vaccination program, however, the Federation for Infectious Diseases is calling for a three-prong program, involving state, federal, and regulatory actions.

THE STATE LEVEL

State programs to curb the spread of HBV include prenatal screening and newborn immunization. Twenty countries already have national programs for universal infant immunization for HBV, and it is absurd that the United States does not, Kuvin said. Other actions at the state level include adding to the Medicaid formula the costs for hepatitis B prevention and treatment, offering free vaccinations to healthcare workers, offering vaccinations at state schools, and providing more training and education. In addition, although child-to-child transmission is not a problem today, Kuvin believes it probably will be, so consideration should be given to vaccinating children and workers in day-care centers.

THE FEDERAL LEVEL

The federal government should, Kuvin said, require all healthcare employers to vaccinate workers at risk; vaccinate and/or screen immigrants from high-risk areas; vaccinate all new military recruits; increase funding for sexually transmitted disease clinics for screening, vaccination, and consultation; and obtain funding to study the cost-effectiveness of immunization for infants and all targeted groups.

THE REGULATORY LEVEL

The goal at the regulatory level is to eventually require universal vaccination. The OSHA proposal requiring vaccination of workers at risk is the first step toward this. Another important step, Kuvin said, would be to integrate hepatitis B programs into all AIDS programs, grants, and contracts, since the diseases are spread identically.

Currently, Kuvin said, only 40 percent of high-risk healthcare workers and 24 percent of physicians have been vaccinated. In addition, only 25 percent of medical and osteopathic schools have any vaccination program at all, although dental schools are more rigid in requiring vaccination.

The conference speakers emphasized that diverse groups such as firefighters, police, and emergency medical personnel will also be included in the vaccination requirement. In addition, affected groups in hospitals extend beyond healthcare professionals to janitors, launderers, waste removal employees, and other contract workers.

UNIVERSAL PRECAUTIONS

In addition to hepatitis B vaccines, a major portion of the OSHA proposal relates to the implementation of universal precautions, which are already in effect in most healthcare facilities. Universal precautions are designed to protect workers from blood-borne pathogens by assuming that all patients are infectious. The precautions entail actions such as wearing gloves and other protective clothing and educating employees, from physicians to housekeepers, to ensure their compliance with universal precautions.

Perhaps the most hazardous and least preventable contact with blood involves needlestick injuries. According to Mason of the HHS, preliminary results at one hospital showed that surgical and scrub personnel are injured with blood-contaminated sharp instruments in 1.2 percent of procedures. The risk was highest—31.4 percent—for surgeons performing emergency surgery for patients in the trauma, burn, orthopedic, and emergency departments.

"The introduction of universal precautions does absolutely nothing to protect surgeons," Day said.

Although for nurses and anesthesiologists 66 percent of exposures could be prevented by use of gloves, Mason said, surgeons need new techniques such as safer ways of passing instruments and stab-resistant gloves (which are currently unavailable.).

UNACCEPTABLE RISK

For at least one surgeon, however, the risk was too high. Lorraine J. Day, MD, spoke of her decision last year to resign as chief of the Department of Orthopedic Surgery at San Francisco General Hospital. On her service, generally 10 percent to 30 percent of patients are HIV positive, but last spring, for about a 12-week period, 90 percent of the patients were HIV positive. She anticipates that high rate will become more frequent in the future and estimates that she would have had a 50 percent chance of being infected with HIV if she continued working there, and so she took a job as vice-chairperson of the Department of Orthopedic Surgery, University of California School of Medicine, San Francisco, which has a lower-risk population.

"When you have a battle going on, there are certain people at the front lines of the battle, but you can't keep them there indefinitely," Day said. "Since I have operated probably on as many AIDS and HIV-positive patients as anyone in the country, I felt that it was time for me to reduce my role."

Day noted that for years the surgeons at San Francisco General had been reducing their risk of infection by passing their sharps in emesis basins, wearing polyethylene gloves between two pairs of latex gloves, and wearing "space suits," which cover the surgeon from head to toe, including a complete face visor.

"Universal precautions are really gowns, gloves, and goggles," she said. "We've been wearing these for decades to protect the patient from contamination from microbes and from our skin, so the introduction of universal precautions does absolutely nothing to protect surgeons."

Day showed the audience numerous slides of what a surgeon looks like after surgery: covered with blood from head to toe, even under a gown. And she noted that orthopedic surgeons get stuck in the operating room approximately

CHA JOINS COALITION

Hepatitis B is just one of many diseases that are vaccine preventable yet still infect more than 20 million Americans a year, killing some 70,000 of them. Most adults are not fully immunized against these diseases—influenza, pneumococcal pneumonia, hepatitis B, diphtheria, tetanus, measles, mumps, and rubella—but the National Coalition for Adult Immunization is trying to change that situation.

Formally established in 1988 by the National Foundation for Infectious Diseases, the coalition has more than 40 members, including medical and healthcare associations, consumer and voluntary organizations, corporations, government agencies, and individuals. The Catholic Health Association (CHA) recently became a member.

In addition to distributing materials during National Adult Immunization Awareness Week, held the last week of October each year, coalition members disseminate information all year. As a member, CHA will report on new developments to promote awareness of the need for adult immunization. Any questions concerning the coalition or the support that CHA can offer its members should be directed to Edwin Fonner, Jr., director of research and information at CHA (314-427-2500).

One problem facilities must deal with immediately, Yezzo said, is price gouging by vendors.

four times a month, just because of the nature of their work. "People who say, 'Why don't you just be careful?' are ignorant of what goes on in an operating room," she said.

Furthermore, Day cited a study by the National Institutes of Health which said that all gloves have holes in them when they are new. And she speculated about the danger of HIV being transmitted through aerosolized blood—particles too small to see, generated during laser surgery or bone drilling, that can float in the air and penetrate surgeons' masks. Although no such transmission has been documented, it has not been disproved either.

Day agreed that surgeons have an obligation to take risks, but she noted that just as firefighters have protective clothing and astronauts have heat shields, healthcare workers also should be protected. "It's good to have research to treat patients who are dying of the disease, to treat patients who are symptomatic, but we have to have research to protect those who don't have the disease because that's the only way we'll get the epidemic under control," she said.

COST BARRIERS

In addition to concerns that the OSHA proposal does not do enough to protect healthcare workers, many in the industry are worried about the added financial burden to already beleaguered healthcare facilities. The cost of the hepatitis B vaccine will be borne by the facilities, as will additional supply, training, waste disposal, and other costs related to universal precautions.

The OSHA proposal estimates the total annual cost of compliance will exceed $852 million, with hospitals bearing nearly $195 million of that burden. Scannell noted, however, that OSHA has received numerous comments suggesting it underestimated these costs, so it is currently revising the estimates.

Much of the money for implementing universal precautions already exists within the facilities, however, and it is just a matter of improving hospitals' efficiency so the money can be redirected and used properly. This opinion was expressed by Richard Yezzo, president of St. Clare's Hospital and Health Center, New York City, a 250-bed acute care facility with a 70-bed unit dedicated to patients with HIV or AIDS.

Yezzo noted that although St. Clare's was in Chapter 11 in 1981 and increased its costs by 35 percent to 40 percent when it started the AIDS program in 1985, it has been able to turn around the financial situation and even make some money. The only way to deal with infectious diseases as a business, Yezzo said, is to decrease the length of stay and generate more discharges to decrease the volume of patients. But he noted this task will get harder as the numbers infected with HIV and HBV continue to rise. And, unfortunately, most state Medicaid systems do not allow an affordable base for hospitals to pay for the problem, Yezzo said.

Another major obstacle is competition among facilities. "Not only are our individual hospitals not being properly managed in terms of good, sound cost-accounting systems and the like," Yezzo charged, "but I submit to you that we don't have a system of healthcare in New York City and probably in other parts of the country that works together, that can appropriately place and treat patients at the level of care that is necessary for them so that we're not misspending money."

Collaborative efforts can work, he said, and he pointed to the Gift of Love in New York City, a house for ex-convicts with AIDS. Mother Teresa's sisters run the house, and St. Clare's pays for the laundry, waste disposal, and medical component. This type of facility helps St. Clare's to keep its costs down because patients have somewhere to go after discharge.

Another problem that facilities must deal with immediately, Yezzo said, is price gouging by vendors of supplies related to universal precautions, drug companies, and other services such as hospices. When St. Clare's established universal precautions in 1986, Yezzo said, it did not set strict criteria and rigid pricing structures, and it did not get mad at vendors who were gouging. Consequently, he said, it is hard to ask the vendors to bring the prices down now.

"I'm not suggesting that we deny profit," Yezzo said, "but I am suggesting that we should try to deny somebody from taking advantage of a bad situation."

Another aspect of working with vendors is training suppliers. For example, St. Clare's showed its laundry supplier how to better protect its employees and handle the laundry more efficiently. This made the employees more comfortable handling items from the AIDS unit and increased efficiency to the extent that next year's laundry budget at St. Clare's will decrease about 10 percent, despite the increased volume.

LEGAL ASPECTS

Another major challenge for hospitals involves the legal aspect of implementing universal precautions. "Universal precautions have begun to emerge as the standard of care—the legal duty owed by healthcare employers to their employees," said Constance H. Baker, JD, partner with Venable, Baetjer & Howard, Baltimore.

Baker thinks OSHA's proposed regulations will clearly require as binding law that healthcare employers protect their employees at risk by offering the hepatitis B vaccine and by training, monitoring, and ensuring compliance with universal precautions. In addition to citations and fines from OSHA, facilities that fail to comply risk major negligence verdicts and workers' compensation recoveries by their employees. Baker believes hepatitis B was "made to order" for the plaintiff's bar because of the strong documentation in the literature regarding foreseeability of injury and means of prevention.

She urged hospitals to start learning about and complying with the OSHA proposals now, since it will take some time to establish an infection control plan and get it approved, to educate employees, and to evaluate products that work. The OSHA standard, she said, "will be staggering in its impact on hospitals in terms of the cost, the distribution of products, the training and education requirements, the monitoring, the compliance, and the paperwork."

Baker advised
facilities not
to write an
overly
ambitious plan.

The infection control plan may be the heart of the proposal, she said. Baker advised facilities not to write an overly ambitious plan that will be difficult to carry out, or they could make more trouble for themselves.

The OSHA proposal represents the first time OSHA has ventured into biological hazards in hospitals, so hospitals will have to learn about OSHA, and vice versa, Baker said. She urged hospitals to avoid an adversarial stance and adopt a learning, cooperative attitude instead. The **Box** below details some recommendations for facilities when they deal with OSHA.

"Hospitals and other healthcare institutions have a very creative opportunity here to provide the training, the education, the vaccine, and the medical care in a way that optimizes, not interferes with, employer-employee relations," Baker said.

—*Susan Hume*

WHAT TO DO WHEN OSHA KNOCKS

After the final OSHA proposal has been approved and put in place, the possibility of inspections—and fines—at healthcare facilities will increase dramatically. To date, OSHA has conducted about 700 inspections of healthcare facilities, issued 2,500 citations, and levied fines in excess of $350,000, according to Ronald Taylor, JD, a senior associate at Venable, Baetjer & Howard, Baltimore.

During their inspections, Taylor said, OSHA will look for noncompliance with its general duty clause (the obligation to protect employees from hazardous situations), as well as with specific standards. Violations can carry fines of up to $10,000 for each instance, so facilities are well advised to limit their exposure.

Taylor recommended the following strategies to limit the amount of fines:

1. Determine whether a state or federal program applies. OSHA allows states to enforce their own occupational safety and health programs, and about 25 states currently do so. In such states, facilities need to worry about that program, not the federal one.

Taylor

2. Determine who will be given responsibility for overseeing compliance, and establish an OSHA response team to conduct periodic checks of departments. In addition to specific departments, OSHA will check records of occupational injuries and illnesses, so these should be kept current.

3. Decide whether you will allow the inspection or demand a warrant. Taylor advised facilities to allow the inspection so they could maintain more control over it.

4. During an opening conference with the inspector, come to an agreement about what will be inspected. Then have someone accompany the inspector wherever he or she goes. You can control the scope of the inspection—and hence the fines—by limiting the number of things the inspector sees.

5. Be certain the representative accompanying the inspector understands the facility's rights and limitations. For example, the management representative does not have the right to listen when an employee is being interviewed, but does have a right to copies of photographs and measurements the inspector takes. The representative also should take notes during the inspection.

6. Be certain that the manager accompanying the inspector does not make an admission against interest, such as agreeing when the inspector points out a potential violation.

During a closing conference, Taylor said, the inspector will list what violations were found. Citations have to be issued within six months of the violation, but the average lag time is 40 days. An appeals process exists and is being increasingly used, he noted. In 1989, 10 percent of cases were appealed, compared with 3 percent in 1987. As facilities become more familiar with OSHA—and its fines—he expects this number to rise even more.

Universal Hepatitis B Immunization

Cost should not be obstacle for HBV vaccine

■ *With 300,000 new cases a year experts agree there is a need*

■ *Universal HBV immunization is essential; cost should not be factor*

by Laura J. Lenze
Staff Writer

WASHINGTON, D.C.—A vaccine that is 90% effective is available worldwide, yet a hepatitis B epidemic rages in the United States today.

To stifle this epidemic, the National Foundation for Infectious Diseases recommends that all infants, children, adolescents, and targeted groups be vaccinated. "We must educate ourselves, our colleagues, and others about this incubating national tragedy that has been caused by a combination of apathy, ignorance, and lack of public and professional education," asserted Sanford F. Kuvin, MD, vice chairman of the Board of Trustees, National Foundation for Infectious Diseases, Bethesda, Md.

A comprehensive program should include universal screening and vaccination of all newborns
Sanford F. Kuvin MD

By providing universal vaccination for all infants, children, and targeted groups, it has been estimated that by the year 2015, hepatitis B could be eradicated from the United States.

"A systemized action to vaccinate target groups in America can and must be carried out at the state, the federal, and the regulatory levels, and this can only be done with your help," Kuvin told fellow physicians at the fourth National Forum on AIDS and Hepatitis B.

A comprehensive program should include universal screening and vaccination of all newborns, universal immunization of adolescents, and special programs for high-risk groups, Kuvin suggested.

Thanks to individual state intervention, some progress has been made. In Ohio, to practice dentistry one must be vaccinated against hepatitis B or show evidence of immunity. Michigan is the first and only state to enact a law requiring prenatal screening. Hawaii and California have programs for screening Southeast Asians. In Connecticut, Yale Medical School requires students to receive the hepatitis B vaccine. However, Kuvin pointed out that these are only the first steps toward the goal of universal immunization.

Each state should initiate prenatal screening as Michigan has and should provide free vaccines for health care workers, Kuvin suggested. Vaccination on the state level for students at state schools who are at risk, health care students before clinical training, health care practitioners, and residents in prisons and institutions are also needed.

On the federal level, health care employers should be required to vaccinate all workers at risk. Medicaid and federal insurance programs are needed. The Immigration and Naturalization Center should be vaccinating or screening all immigrants from high incidence areas. The Department of Defense should be vaccinating all military recruits for the pilot program in South Korea, but the DOD claims it does not have the necessary funds for the program, Kuvin remarked.

clinics. Money is needed for these clinics to provide screening, consultation, and vaccination. Cost-effectiveness studies must be done to carry out universal vaccination for infants, adolescents, and all targeted groups, Kuvin noted.

Twenty countries around the world have national programs for universal infant immunization. Japan is already vaccinating children and workers in day care centers who show no evidence of immunity.

Worldwide there have been 27 published case reports of HIV infection in high-risk health care workers who have occupational exposure to blood. Nineteen of these cases are in the United States and two of these have AIDS. The Centers for Disease Control estimated that in 1987, 12,000 hepatitis B infections occurred in health care workers with exposure to blood resulting in 250 deaths.

Experimental sex, intravenous drugs, homosexuality, tatooing, ear piercing, manicuring, and contact sports all spread hepatitis B. HBV spreads by the same methods as AIDS—sex, blood, needles, and birth. Thus, hepatitis B programs should be integrated into all AIDS educational and prevention programs, grants, and contracts, Kuvin suggested.

This is the first time in history that the discovery of an effective vaccine has not been followed by a decreased incidence of the infection. Incidence is actually on the rise.

In 1988, 300,000 new infections occurred with an estimated 1.8 million chronic carriers in the United States, and almost 300 million chronic carriers worldwide. About 60 million of these carriers, as well as 1.8 million children born in 1988, will die from the sequelae of hepatitis B infection, Kuvin said.

More than 25% of chronic carriers of hepatitis B progress to primary liver cancer, one of the most common types of cancer. Thus, one can prevent cancer by preventing hepatitis B through immunization, he pointed out.

About 30 million Americans need vaccinations today. The largest target groups include sexually active heterosexuals, who account for 22% of new infections; IV drug abusers, 26% of new infections; and homosexuals, about 5%. Other major groups include newborns with HBV antigen, positive pregnant women, prisoners, institutionalized mental patients, Eskimos, and Asian and African immigrant groups.

Of the HBV vaccines that have been given in the United States, 90% have gone to health care workers. However, only 40% of all health care workers have been vaccinated, with only 24% of all physicians having been vaccinated.

Cost should not be a major obstacle. Two manufacturers, Merck Sharp & Dohme and SmithKline Beecham, have entered into the competitive American marketplace, and the cost has already begun to fall, according to Kuvin. In Israel, where they now have three manufacturers competing, the cost of the series of three doses fell from $120 to its current level of $45 in only three months. "So, eventually the cost will come down," Kuvin explained.

"Hepatitis is infectious for life," Kuvin concluded. "We are developing the weapon against AIDS, but we have developed the weapon against hepatitis B. We must be proactive rather than reactive." This safe and effective vaccine is the best prescription to protect the health of the American people, he said. ■